U.S. Department of Labor

Office of Administrative Law Judges
John W. McCormack Post Office and Courthouse
Room 505
Boston, MA 02109

(617) 223-9355
(617) 223-4254 (FAX)

Issue date: 23Sep2002

CASE NO.: 2001-LHC-2932/2933

OWCP NO.: 1-146149/144649

In the Matter Of:

WILLIAM J. TALAR
Claimant

v.

ELECTRIC BOAT CORPORATION
Employer/Self-Insurer

and

Director, Office of Workers' Compensation Programs
U.S. Department of Labor
Party-In-Interest

APPEARANCES:

Carolyn P. Kelly, Esq.
Nathan Julian Shafner, Esq.
For the Claimant

Alexander P. Borré, Esq.
Edward W. Murphy, Esq.
For the Employer/Self-Insurer

Merle D. Hyman, Esq.
For the Director

BEFORE: **DAVID W. DI NARDI**
District Chief Judge

DECISION AND ORDER - AWARDING BENEFITS

This is a claim for worker's compensation benefits under the Longshore and Harbor Workers' Compensation Act, as amended (33 U.S.C. §901, **et seq.**), herein referred to as the "Act." The hearing was held on April 18, 2002 in New London, Connecticut, at which time all parties were given the opportunity to present evidence and oral arguments. The following references will be used: TR for the official hearing transcript, ALJ EX for an

exhibit offered by this Administrative Law Judge, CX for a Claimant's exhibit, DX for a Director's exhibit, JX for a Joint exhibit and RX for an Employer's exhibit. This decision is being rendered after having given full consideration to the entire record.

Stipulations and Issues

The parties stipulate (JX 1), and I find:

1. The Act applies to this proceeding.

2. Claimant and the Employer were in an employee-employer relationship at the relevant times.

3. Claimant alleges that he suffered an injury on July 17, 1998 in the course and scope of his employment.

4. Claimant gave the Employer notice of the injury in a timely manner.

5. Claimant filed a timely claim for compensation and the Employer filed a timely notice of controversion.

6. The parties attended an informal conference on July 25, 2001.

7. The applicable average weekly wage is $676.33.

8. The Employer voluntarily and without an award has paid temporary total and/or partial compensation for various periods of time and these benefits total $58,280.62. (JX 2) Medical benefits total $25,249.70.

The unresolved issues in this proceeding are:

1. Whether Claimant's current medical pulmonary condition is causally related to his maritime employment.

2. If so, the nature and extent of his disability.

3. The Employer's entitlement to the limiting provisions of Section 8(f) of the Act has been withdrawn as an issue herein.

Post-hearing evidence has been admitted as:

Exhibit No.	**Item**	**Filing Date**
CX 24	Attorney Shafner's Deposition Notice relating to Carl E. Barchi, M.Ed., CDMS	05/02/02

RX 12	Attorney Borré's letter filing the	06/12/02
RX 13	May 15, 2002 Deposition Testimony of Daniel R. Gerardi, M.D.	06/12/02
CX 25	Attorney Kelly's letter (1) advising that Attorney Shafner had left her law firm and (2) filing her	07/08/02
CX 26	Fee Petition relating to services rendered and litigation expenses incurred between January 13, 2002 and June 20, 2002	07/08/02
RX 14	Attorney Borré's letter confirming an extension of time for the parties to file their post-hearing briefs	07/10/02
CX 27	Attorney Shafner's letter filing the	07/11/02
CX 27	May 21, 2002 Deposition Testimony of Carl E. Barchi	07/11/02
CX 29	Attorney Shafner's letter filing the	07/17/02
CX 30	**Curriculum Vitae** of Mr. Barchi	07/17/02
RX 15	Attorney Borré's status report	08/09/02
JX 2	The Parties' Additional Stipulations	08/28/02
CX 31	Attorney Kelly's revised Fee Petition	09/06/02
RX 16	Attorney Murphy's letter advising that he has no objections to such fee petition	09/11/02

The record was closed on September 11, 2001 as no further documents were filed.

Summary of the Evidence

William J. Talar ("Claimant" herein), fifty-eight (58) years of age, with a ninth grade formal education and an employment history of manual labor, began working on July 2, 1962 as a sheet metal worker at the Groton, Connecticut shipyard of the Electric Boat Company, then a division of the General Dynamics Corporation ("Employer"), a maritime facility adjacent to the navigable waters of the Thames River where the Employer builds, repairs and overhauls submarines. He continued to work at the shipyard until

November 25, 1998, except for layoffs from June 30, 1967 to October 28, 1968 and from October 2, 1970 to July 16, 1973, when he went to work elsewhere. (CX 1) As a sheet metal mechanic Claimant worked with and was exposed to and inhaled asbestos dust and fibers and other injurious stimuli, especially as he worked in close proximity to pipe laggers, grinders, welders, painters, shipfitters and other trades who were generating dust, smoke and fumes into the ambient air of the work environment. The cutting and application of asbestos as insulation around machinery, equipment and hot pipes caused asbestos dust and fibers to float around the work area to such an extent that the area resembled a dust storm. He wore no air-fed face masks or respirator in the performance of his assigned duties, although in the late 1980s he was provided "flimsy" paper masks. (TR 19-30)

While Claimant has never smoked any tobacco products, he has been exposed to so-called second-hand smoke as the shipyard workers were at one time allowed to smoke on the boats and in the shops. He began to experience shortness of breath around 1986 and gradually any physical exertion aggravated his breathing. In late 1997 he went to the Yard Hospital, complaining about his shortness of breath; x-rays were taken and these were sent to Hartford for further evaluation. Claimant was told to see his own doctor and he went to see John Bigos, M.D., a pulmonary specialist. (TR 30-47)

Dr. Bigos states as follows in his September 21, 1998 **Consultation Report** (CX 5):

This consultation was requested prior to thoracoscopic procedure tentatively scheduled for September 28, 1998 at Lawrence and Memorial Hospital by Dr. Michael Deren.

The patient is a 54-year-old gentleman whom I first saw on August 17, 1998 for evaluation of shortness of breath. The patient in June, 1998 had atelectasis involving the left lower lobe on his chest x-ray. He is a nonsmoker and he noted over the past ten years increasing shortness of breath recently manifested by one flight dyspnea on exertion.

PAST MEDICAL HISTORY: 1) Remarkable for having been hospitalized for kidney stone in 1973. 2) He had right eye removed due to a piece of steel being embedded in it in 1996. 3) Colitis for which he sees Dr. Greenwald and has a yearly colonoscopy. He has no known cardiac history and no history of chest pain. He has no nausea, vomiting, diarrhea or history of tuberculosis.

OCCUPATIONAL HISTORY: Quite remarkable having been employed at General Dynamics from 1962 to present. During the 1960s he was a sheet metal worker there and had asbestos exposure in the 1960s and would (sic) asbestos gaskets. In the 1970s and 1980s the patient said there was less asbestos. He had no hemoptysis, no weight loss and no paroxysmal nocturnal dyspnea...

EXTREMITIES: Remarkable for arthritic type changes.

The patient also complained of daytime somnolence, snoring and question is raised about sleep apnea.

CAT was performed of his chest. On walking approximately 150 feet the patient would be desaturate from 96 to 91% with a change in heart rate going from 70 to 87. The patient had had extensive blood work done and a CAT scan of his chest.

I refer the reader to the actual report. Briefly, mention is made of thickening of the diaphragmatic surface, more prominent on the left. It should be noted on September 21, in discussion with the patient he said that he had been involved in a motorbike injury where he had fallen off and over the handlebars of the motorbike and injured the left side of his chest but never sought medical help after that. There was no chest x-ray immediately post that. The patient had seen Dr. Deren on September 8 and is going to see Dr. Deren again on September 23 and I have discussed the issue with Dr. Deren on September 21.

The patient had pulmonary function tests performed and those pulmonary function tests revealed uniform diminution in flow-related values such that his FEV1 was 2.7 liters at 77% of the predicted. His forced vital capacity was 3.11 liters at 76% of predicted. His FEV1/FEC ratio was 87% of predicted or supernormal. His total lung capacity was 58% of predicted at 3.98 liters, residual volume was reduced and the patient's diffusion capacity was normal at 93% of predicted...

In discussion today the patient has a number of issues. He has the abnormality on CAT scan as mentioned. I have discussed this with Dr. Deren. It is possible that this in part could be thrombo-related. Dr. Deren will see the patient on September 23. The patient will bring all old x-rays or x-ray reports and see if there is anything to suggest that this was present prior to 1998. The patient at minimum should have a repeat CAT scan in December, 1998.

The patient also has a question of sleep apnea and is polycythemic. He will have a room air blood gas performed today and will follow up then.

In summary, the patient is polycythemic and will have room air blood gas done. Will attempt to find prior chest x-rays from greater than six years ago at the time of the motorcycle accident and see if the changes were present before or immediately post this event.

The patient will return in two weeks and further decisions will be made, according to the doctor.

Claimant's multiple medical problems are summarized by the

November 30, 1998 **Discharge Summary** of Michael M. Deren, M.D., wherein the doctor reports as follows (CX 11):

DISCHARGE DIAGNOSIS: Asbestosis, plaque with epithelial hyperplasia, proteinuria, adenomas polyps by history, history of ulcerative colitis, polycythemia vera and emphysema.

DISCHARGE MEDICATIONS: Lomotil, two tablets PO BID. Azulfidine 500 mg, two tablets BID. Folic acid 1 mg PO Q day.

ALLERGIES: None.

OPERATIONS AND PROCEDURES: On 11/27/98 a thoracoscopy with biopsy of lung and pleura.

HISTORY: This 54-year-old white male was admitted to the hospital because of shortness of breath dating back to 1986. he noted this first in 1986 when he was unable to swim underwater as far as he once could. Gradually this shortness of breath increased to the point where he could only climb one flight of stairs. He was seen in June of this year. He was referred to Dr. Greenwald who subsequently referred him to Dr. Bigos. CAT scan performed showed pleural based lesion on the left lower lobe as well as fibrosis bilaterally at the lung bases. He has undergone extensive evaluation and following of this lesion. X-ray and other evaluations have not been able to determine whether this is benign or malignant. There is a question that the patient had a tumor located in the lower lobe. He has denied any paroxysmal nocturnal dyspnea, orthopnea, wheezing or hemoptysis. He has had no temperature elevations, chills or fever.

PAST MEDICAL HISTORY: He has a past medical history of polycythemia vera. He has had a sleep study as the result of this. It was an incidental finding. He has been under the care of Dr. Sager for this. He also has a history of ulcerative colitis, diagnosed in 1971 and regulated on Lomotil and Azulfidine. He has not had any gastrointestinal bleeding for the past five or six years and is under the care of Dr. Greenwald for this. He has also had a history of adenoma discolonic polyps and proteinuria being evaluated by a nephrologist.

PAST SURGICAL HISTORY: He had nucleation of the right eye secondary to a work accident. He has had a pyelolithotomy secondary to nephrolithiasis many years ago. He has had no problems with anesthesia in himself or in his family members.

ALLERGIES: He denies any allergies to food or medications.

MEDICATIONS: His medications include Lomotil two tablets PO BID, Azulfidine 500 mg two tablets PO BID and folic acid 1 mg Q day.

He has had a history of exposure to asbestos over the years...

SOCIAL HISTORY: He is married and has two children. He worked as a sheet metal worker at Electric Bow (sic). He has never smoked. He has occasional alcohol use. He has no special diet. Rare caffeine intake.

REVIEW OF SYSTEMS: As in history and physical.

PHYSICAL EXAMINATION: His blood pressure is 156/92, heart rate is 74 and regular, respiratory rate is 18 and unlabored. Examination of the head, eyes, ears, nose and throat was unremarkable except for his enucleation of the right eye. His lungs have decreased breath sounds at the bases. There are no rubs. His heart has a normal sinus rhythm. There is normal S1, S2. No murmurs were noted. The abdomen is soft and non-tender. Extremities are unremarkable...

Patient was taken to the operating room on 11/27/98 and underwent a left video assisted thorascopic surgery with biopsy of the pleura and lung in the left lower lobe. The patient had diffuse parietal pleural plaquing which on frozen section was benign. The mass located in the left lower lobe was indeed diaphragmatic.

Post-operatively the patient did well. He had no evidence of air leak and minimal drainage. His chest tube was subsequently removed. IV stopped. Diet advanced. Activity increased such that he was doing well and was discharged on the third post operative day to be followed in the office. Pathology showed fibrous pleural plaques with hyperplasia. The left lower lung biopsy showed lung tissue with emphysematous changes, according to the doctor.

Dr. Deren states as follows in his October 30, 1998 report to Dr. Bigos (CX 9):

Just a brief note to give you follow-up on William Talar. As you know he has an abnormal CAT scan which has shown pleural thickening in the base of the left lung. His x-rays which are several years old from EB were essentially unremarkable and I think really non-contributory.

He is currently seeing Dr. Diane Sager and will have repeat CAT scan in the near future following which he will be seen in follow-up by me. He understands the importance of the x-rays and follow-up and has assured me that he will be seeing me in approximately two weeks or less, according to the doctor.

As of November 10, 1998, Dr. Deren reported as follows to Dr. Bigos (CX 10):

William Talar was seen in the office on 10/21/98. He had repeat CAT scan of the chest which again demonstrated an abnormality

located at the base of the left lung. A chest x-ray was suggested by the radiologist to help differentiate this from an elevated diaphragm and other conditions. This was performed and found not to be helpful. I have urged him to come back to the office and we can make a final disposition as to whether we should continue to observe this or consider surgery or possibly get another opinion. He will be seeing you in the interim, according to the doctor.

As of December 7, 1998, Dr. Deren's diagnosis was "fibrous pleural plaques-mesothelial hyperplasia." (CX 12)

Dr. Bigos sent the following letter to Dr. Deren on December 16, 1998 (CX 13-1):

I saw Mr. Talar today, December 16, 1998. I know you just saw him and will be following him closely. I suggested he get a repeat CT scan in mid-February, 1999. He also needs a sleep study repeated. I have stressed the importance of this. I will be forwarding a copy of the September 25, 1998 consultation to Alan Greenwald from Dr. Sager, my consultation from September 21, 1998 and the material from the Sleep Disorder Center of Eastern Connecticut from November 19, 1998. I have stressed the need again for a repeat sleep study. Mr. Talar does not want to use his CPAP and I do not know if he would benefit from supplemental oxygen at night, according to the doctor, who kept Claimant out of work as totally disabled for all work as of December 16, 1998 (CX 13-2) and again as of January 21, 1999. (CX 15-1) Asbestosis continued to seen on Claimant's February 12, 1999 diagnostic tests (CX 16-1) and Dr. Bigos kept Claimant out of work. (**See, e.g.,** CX 17-1, CX 18 at 1-4)

Dr. Deren issued the following report on September 7, 1999 (CX 21):

William Talar was seen in the office on 8/30/99 at your request for evaluation of a disability status. The patient was seen by me on 9/8/98 having been referred by Dr. Bigos for evaluation of a left pleural based mass. The patient has had a complex past history and evaluation. In summary he underwent a left video assisted thoracoscopic biopsy of the parietal pleura and lung biopsy on 11/27/98. This demonstrated benign tissue compatible with mesothelial hyperplasia of the pleural plaques and chronic obstructive pulmonary disease on lung biopsy. He did well following that and I last saw him on 12/30/98. At that time he was referred back to Dr. Bigos and was not seen until 8/30/99 when he was sent by you, for disability status. His medications at this time include Cardizem CD 120 mg qd, Clonazepam 0.5 mg qd, Combivent and Flovent inhalers, Lomotil, folic acid and sulfasalazine. The patient has not been working since his surgery. He has undergone evaluation with a sleep study since that time under the direction of Dr. Mohsenin. He was placed on a sleep pill called Clonazepam and now sleeps well. He was also evaluated by Dr. Van Mlynarski for his breathing problems but apparently he is breathing well. He

also has been seen by Dr. Daniel A. Gerardi of St. Francis Hospital. He was seen on 2/3/99 for evaluation of disability. Dr. Gerardi did an extensive evaluation and his conclusion was that the patient had "significant exposure to asbestos with subsequent development of bilateral calcified pleural and diaphragmatic plaques. Based on the history that I have obtained today I believe his plaques are causally related to his work for the Electric Boat Shipyard in 1960's were he was exposed to asbestos in the construction and renovation of submarines."

I reviewed a IME by Dr. Gerardi of Hartford who said," if needed currently I would estimate his impairment to be 15% for both lungs and the whole person based on the AMA **Guides to the Evaluation of Respiratory Impairment**, 4th Edition 1993, equally divided between restrictive changes related to obesity and those related to the recent thoracoscopic surgery. I also suggest, of course, that he be followed periodically with pulmonary function studies and perhaps radiographically for the development of any further manifestations of asbestos related disease. He is currently seeing a very experienced pulmonologist in Dr. Bigos to this end.

The patient's current sym0ptoms are fatigue and shortness of breath. The patient can walk well but notes shortness of breath when climbing one flight of stairs. He has inhalers which have helped. He notes his shortness of breath is worse when it is warm and humid. He cannot go near anyone who is smoking or smoking sections because of the shortness of breath. He notes that fatigue is a problem and he has some trouble sleeping but recently has been sleeping well with his medication.

A CT scan of the chest performed on 8/14/99 showed "no change."

On physical examination his lungs are clear to auscultation and percussion, his chest has a slightly increased AP diameter and slight decrease motion of the diaphragms. All wounds have healed without problems. His heart had a normal sinus rhythm, his neck had no palpable supraclavicular or cervical adenopathy. Pulmonary function tests, a copy of which I have from St. Francis Hospital, dated 2/3/99 showed a "mild mixed reduction in flow parameters consistent with a mild restrictive ventilatory defect, at least in part related to the patient's obesity. There are no prior studies available for comparison."

IMPRESSION: I believe Mr. William Talar has asbestos related pleural plaques, currently of a benign nature. He also has evidence for chronic obstructive pulmonary disease although he has never been a smoker. In addition to this he has ulcerative colitis and a sleep apnea syndrome. He has currently lost 30 pounds and does not in my estimation appear to be obese or mildly obese.

He also has no evidence of pain in his chest secondary to his video assisted thoracoscopic surgery.

I have no current pulmonary function tests which I think would be critical in evaluating any disability.

I would point out that this patient is being followed by Dr. John Bigos and would refer the patient back to him because he is more familiar with him and has been following him for evaluation of his disability. At present, I do believe that he does have pleural based disease related to his work at Electric Boat, the percentage impairment would depend on repeat pulmonary function tests which would not now be related to pain from the thoracoscopy or due to obesity, according to the doctor.

Claimant's orthopedic problems are summarized by the March 22, 2000 report of Edward J. Collins, M.D., wherein the doctor reports as follows (CX 22):

Patient is here today for right shoulder pain.

This 56-year-old gentleman, who worked for 35 years as a sheet metal worker for Electric boat, has complained for many years of increasing subacromial shoulder pain aggravated by his work activities. He describes his work activity as that of holding metal parts and using grinding wheels, etc. on a repetitive basis. Notes that these activities specifically seem to aggravate his discomfort. Continued to work with this discomfort but has not worked in the last 14 months due to asbestosis and rehabilitation he is undergoing for this. Also has a history of ulcerative colitis. Notes that he has never been treated for his shoulder complaints. Also notes that since he has discontinued working, he still has achy pain, although it is not quite as severe as it was during the time when he was working. Has pain on a daily basis. Also has noted accompanying restriction of motion of his shoulder, which has developed over the years. He feels his symptoms are essentially stabilized at the present time. He is currently not being treated. Other systems are negative.

He has recently been seen by Dr. Browning on 12/99 and has been rated as having a 5% PPD relative to each shoulder. Had x-rays at that time.

On examination today first of the head and neck shows he has full range of head and neck motion. This does not produce shoulder pain. Examination of the shoulders demonstrates anterior tenderness over the greater tuberosities of the humerus. Pain on stressing the supraspinatus bilaterally. Positive impingement test bilaterally. No pain on stressing the biceps. Full passive glenohumeral abduction. No evidence of instability. On range of motion testing of the shoulders, he has unlimited flexion but has limitation of extension to about 20-25 degrees and internal rotation to 30 degrees. Doesn't have restriction of abduction or adduction.

X-rays are essentially negative.

This gentleman is suffering from a chronic impingement syndrome secondary to chronic rotator cuff tendonitis, I believe related to his work activity as a sheet metal worker for many years. Based on his limitation of range of motion and using the **AMA Guides for Evaluation of Permanent Impairment**, 4th Edition, I feel he has a 5% disability in each upper extremity as a result of his restricted shoulder motion.

As far as any intervention is concerned, this man may well benefit from a course of nonsteroidal anti-inflammatories, **i.e.** a COX-2 inhibitor, **i.e.** Vioxx, and he would also benefit by physical therapy modalities addressed to the shoulders as well as his general pulmonary rehabilitation, according to the doctor.

Dr. S. Pearce Browning, III, a noted orthopedic and hand surgeon, examined Claimant on December 4, 1997 and the doctor reported as follows in his report (CX 22-7):

I saw Mr. Talar in the office on December 4, 1997. This is a complex matter, as I will outline. At the present moment, Mr. Talar is still working for Electric Boat. He started at E.B. in 1962. He had a couple of years out during which he delivered milk and worked for Coca-Cola as a truck driver, but in no place did he use air or vibrating tools. He went to work for E.B. just out of high school, and he has been a sheet metal worker or mechanic during this entire time. He uses air-driven sanders, drills, burring machines, nibblers every day. His principal job is making some pipe coverings and these are made with a set of rollers where you have to turn the rollers by hand. He has made them for all 16 tridents and at least 10 688 boats. At the present moment, he's working on the second Seawolf.

He has had two injuries to the neck, one when he carried a safe down that weighed over 100 pounds.

Mr. Talar is 53 years old, white, has gray hair and bald on the top; height 5'9 1.2", weight 220 pounds, and he right-handed.

In his system review, he had an injury to the eye in 1975 and eventually the right eye was removed. This was a compensible injury at work. He apparently was seen by the audiologist and told that he had a significant hearing loss in the left ear that he could report, but he hasn't reported it as yet. I recommend that he does report this. His heart has not been a problem. More recently he has been short of breath and he has an increased chest size. The chest measures 45-46", so that he has an expansion that's less than it should be. He also gets short of breath climbing a flight of stairs rapidly, although he is able to bicycle for 10 miles. He does have asbestos exposure.

In 1971, he came down with ulcerative colitis. This has quieted down. He is followed by Dr. Greenwald on Montauk Avenue in New London. His medications include Lomotil and Asulphadene.

He has no history of diabetes, thyroid disease, anemia, phlebitis, Lyme disease - he was tested and it was negative. His surgery includes the eye noted above, and a kidney stone in 1972. He has never smoked and he has not used alcohol for the last 32 years.

He has been exposed to welding fumes and this may account for part of the respiratory problem.

I got an x-ray of the neck. Incidentally, on his first visit to Dr. Wainright, there is a complaint of pain in the neck and shoulder area (in the first paragraph of February 14, 1994), and at that time, Dr. Wainright felt that he had problems in the cervical spine as well as the hands.

He also saw Dr. Masterson about two to three years ago about the neck, and I have written for those records.

An x-ray of the right shoulder shows no clear fracture or dislocation. In both clavicles it appears like there is a large artery entering the clavicle and on the left it's similar but doesn't look like a fracture. He says that he has never fractured either clavicle.

Enclosed is a copy of the material I received from Dr. Wainright, and Mr. Talar was kind enough to go over and get it.

I will be writing to Norwich Radiology Group for a copy of the report of the CT scan of the neck that Dr. Masterson ordered, and a copy of the office notes from Dr. Masterson and Dr. Chris Glenney.

This gentleman has a good deal of pain up near the shoulders but it's not that clear as to where it's coming from. He does have some problems in the neck. He has vibration disease in the hands. He may have some element of arthritis secondary to inflammatory bowel disease (the ulcerative colitis). A look at his lumbar spine shows that he has changes in the S1 joint and that at one time the back was injured and the L5-S1 is bridge anteriorly.

I have sent him for lab work and also scheduled him for the Vascular Lab for March 6, 1998. This is the earliest appointment we can get. He will be continuing to work at E.B.

I will see what the CAT scan of the neck looks like and also what Tom Masterson's opinion was. It's going to take awhile to get this altogether. As far as a Section 8 application is concerned, I would point out that he has lost an eye and that, therefore, any present problems are not the sole cause of his disability but will

result in increased total disability beyond that caused by the loss of the right eye, according to the doctor.

As of May 25, 1998, Dr. Browning reported as follows (CX 22-4):

Enclosed is a copy of my recent office note of May 14, 1998 on Mr. Talar.

He has hand-arm vibration syndrome, and the vascular study looked all right and I'm waiting for Dr. Alessi's written consultation report; but I have the measurements back and these show a moderately severe bilateral median mononeuropathies at the wrists. In view of this, I would raise the rating on his hands to approximately 12%, based on the "**AMA Guide**" that mild residual is 10%, and moderate is 20%. This would also include some mild vascular changes.

As far as the back is concerned, this has been bothering him significantly and I wish to get an MRI on the back. The first two injuries to the back are Electric Boat's responsibility, the third is Gilman, and I think that we need to find out who is going to pay for the MRI before I book it, according to the doctor.

As of May 14, 1998, Dr. Browning reported as follows (CX 22-5):

... Patient returns. This time we're dealing with the neck, back and the hands.

He had 2 injuries to the back at Electric Boat and 1 at Gilman. He now has gone to work for Eagle in Colchester.

X-rays of the neck indicate damage to the cervical discs at C5-6 and C6-7. Apparently he has seen Philo Willetts. Dr. Wainright gave him 4% on the carpal tunnels.

At this point, he's having a lot of discomfort in the lumbar spine and I would like to do an MRI, according to the doctor.

As of May 30, 1995, Dr. C.C. Glenney reported as follows (CX 22 at 10-12):

This patient is a 51-year-old male who has been followed by Dr. Thomas Masterson at this office until Dr. Masterson's retirement. He is sent to me by Mr. Timothy Spayne, his (former) attorney, for clarification of his residual disabilities following an injury to his neck while employed at Electric Boat Co.

This patient first saw Dr. Masterson for this on 8/29/94. He gives me the history that he developed neck pain after lifting a heavy safe, in either the winter of 1990 or 1991. He estimates the safe

to weigh 150 lbs. He carried it by himself down two flights of stairs. As he set it down, he felt a pulling pain in his neck with radiation of pain into the right shoulder and arm. He felt a clicking sensation in both these areas as he moved them. He was seen at the Electric Boat Hospital and was diagnosed as having a sprain. He was advised that if the pain continued, he should see his own doctor.

The pain did continue and was very severe in both his neck and radiating to both his arms so he went to see his regular physician who is Dr. Basu. Dr. Basu had seen him previously for sinus infections and treated him with an antibiotic, and the patient hoped this would require similar treatment and be as successful. Dr. Basu x-rayed his sinuses and found them to be uninvolved. She also did an EKG to rule out any heart problem. She advised him he should see an orthopedic surgeon. It was suggested to him to use Advil to try and control his pain.

His pain has continued at a similar level since that time. It does wax and wane to a degree in an intermittent pattern. It is aggravated by increased physical activities such as his work in his yard or home.

He developed wrist and hand symptoms in the summer (of) 1993 and was seen at L&M Occupational Health Center. Initially, he was tried on a course of Motrin for a month's time. This seemed to relive the pain but had to be stopped because his gastrointestinal physician, Dr. Bobruff, felt the Motrin might be harmful to his ulcerative colitis. When the Motrin was discontinued, the pain returned and he was seen by Dr. Moalli, neurologist. With EMG studies, a diagnosis of bilateral carpal tunnel syndrome was made, the left being more severe than the right. It was felt that his symptoms were not so severe that surgery was advised. He was treated with wrist braces and no particular medicines, specifically, although he was advised to use OTC Tylenol for pain.

The compensation carrier evidently sent him to a doctor in Hartford for an IME who agreed with the diagnosis of carpal tunnel syndrome. The physician in Hartford noticed he had a problem with his neck, in the manner in which it was positioned, and x-rayed him. He did not mention arthritis to the patient specifically but described his neck as "not that of a healthy 50-year-old male." He was advised to see an orthopedic surgeon who took care of neck problems and was offered an appointment in his office with one of his associates. He reported this to his attorney, Mr. Timothy Spayne, called workmen's compensation and got permission for him to be examined by Dr. Thomas Masterson in this office. He saw Dr. Masterson on 8/29/94. After Dr. Masterson's examination, he felt he had a cervical radiculopathy and related it back to the incident of trauma that occurred with lifting the heavy safe.

The patient explains to me that for the past 18-20 years, he has

been on the same job at EB with a beading machine for pipe covers. He works this machine with repetitive winding motion of his right arm while he grasps the material which he is beading with his left hand. The material he works with is stainless steel, gauge 22. It ranges from 2" to 36" in diameter and weight from 2 oz. to 8 lb. While grasping the heavier weights with his left arm and winding with his right arm, his neck is stressed due to the angle which he must assume while holding the material and winding with his right arm. His present symptoms are persistent pain in the neck. This has been with him since the incident with the safe occurs. It waxes and wanes in intensity. He recognizes accentuation of the pain if he turns to the right or the left. He also recognizes aggravation if he extends his neck as with an upward gaze or when he is doing his beading job and glances to the right and upwards to observe his area of work. He feels a warmness and pin in the upper aspect of the arm towards which he is turning his neck. He feels a cracking sensation in his neck as he turns it. These symptoms affect his sleep at night. He has difficulty getting comfortable and getting off the sleep. He is often awakened at night with pain. When he awakes in the morning, his neck is stiff and sore. Also when he awakes, he has the sensation that the 3rd and 4th fingers of his hand, either right or left, but more commonly on the left, are swollen and numb.

Two months or so ago, he was re-examined by Dr. Wainright who had seen him for the diagnosis of carpal tunnel syndrome after his consultation in Hartford. Dr. Wainright had a repeat EMG study which, again, revealed carpal tunnel syndromes. Again, the decision was made that the symptoms were not sufficiently severe to warrant operative treatment. Dr. Wainright assigned a 4% permanent partial disability rating to his hand due to his carpal tunnel syndrome.

Exam: The patient appears to have some asymmetry of his head tilt and facial fullness on observation. His neck and head are turned slightly to the right. There is a fullness and a convex silhouette of the right side of his cheek and jaw as compared to the left. He is tender to palpation of the cervical spine at about mid level and downwards. This is both in the mid line and over the paravertebral cervical musculature. His head and neck turn through 50% of normal range to the left and to the right. At this point, he is uncomfortable and becomes painful if he attempts to move it further. He extends his head and neck 25% of normal and, again, if he attempts to push this, he becomes painful. He can flex nearly fully but at the extreme of motion, if he holds this position, his neck again becomes painful. On turning movements of the neck, he has subjective crepitation that he hears transmitted to his ears. His DTRs are symmetrically absent at biceps, triceps and brachioradialis areas. His upper extremity musculature is strong. His muscles are firm and, on individual muscle strength testing, there is no isolated weakness. I do recognize a positive Tinel’s sign bilaterally at his carpal tunnel. A carpal tunnel flexion

test is not particularly positive today.

I believe the patient sustained a sprain injury of his cervical spine in the incident when he lifted a heavy safe while employed at EB. I believe that his symptoms that have been persistent since that date have been aggravated by the repetitive motions of his upper extremity and neck in performing his work since that time. I feel that he has a symptom complex, physical findings on examination and on his imaging studies that indicate he has a 10% permanent partial disability of cervical spine due to the initial traumatic incident and the repetitive movements performed at his work since the date of that trauma.

X-ray studies are reviewed today. Cervical spine films dated 8/29/94 taken in this office reveal multi-level degenerative changes at the apophyseal joints. On oblique views, the neuroforamina are not seriously impinged upon by this degenerative change. Disc spaces reveal no particular narrowing or degeneration.

A CT scan by Norwich Radiology, dated 9/8/94, is reviewed and no disc rupture is revealed. There are degenerative changes at the apophyseal joints.

Treatment: The patient is advised a trial of Relafen 1000 mg daily p.c. Because of his ulcerative colitis, he will stop taking this if he develops any GI symptoms. This medication, however, is less likely to aggravate his colitis than is the Motrin to which he had a good response as regards his pain previously. He is also asked to try a contour pillow at night which may control some of his neck positioning and render him more comfortable through the night. I believe that the symptoms of the 3rd and 4th fingers when he awakes are more likely due to his carpal tunnel syndrome than to his neck problem, according to the doctor.

As of October 28, 1994, Dr. Thomas J. Masterson, as orthopedic surgeon, reported as follows (CX 22-17):

I had the occasion since we last wrote to you to see Mr. Talar for progress evaluation in our office on October 28, 1994. He did undergo a CT scan of his cervical spine and no evidence of disc herniation was noted. He did show evidence of fairly extensive arthritic changes in the spine, which we knew from his plain films.

William was started on one of the non-steroidal anti-inflammatory drugs with satisfactory response and no aggravation of his underlying colitis.

This individual has sustained multiple injuries to his cervical spine and the cervical radicular components of his problem are responsible for the shoulder discomfort that he is having and, therefore, I feel that his problem is strictly neck. As I

understand, this has been covered according to Lauren Bodner at the Electric Boat, according to the doctor.

As of July 6, 1994, Dr. J.P. Zeppieri, an orthopedic surgeon, reported as follows in his report to the Employer (CX 22-22):

Mr. Talar is a 50 year old right-hand dominant sheet metal worker at Electric Boat Company. He complains of bilateral shoulder pain and difficulty with lifting things above shoulder level. Symptoms have been with him since 1991 or 1992. He has also been told that he has carpal tunnel syndrome since then. He describes symptoms in his hands as tingling in the fingers. He is awakened maybe two out of seven nights and has frequent morning symptoms. He does have some symptoms with fixed wrist activities. He has no symptoms writing and he is not dropping things.

On examination of the shoulders he is a muscular man. He has full range of motion. He has mild pain on the extremes of elevation. No A-C joint tenderness. No tenderness beneath the acromion. We can recreate his pain with adduction and flexion of the shoulder against resistance. This is relatively minor on both sides.

Examination of the hands shows no evidence of forearm compression test. There is no Tinel's sign, no symptoms with compression of the carpal tunnel manually, and he has negative Phalen's sign. Two point discrimination is intact. There is no thenar weakness on either side.

By history he has rotator cuff impingement syndrome and carpal tunnel syndrome bilaterally.

I do not think he is a surgical candidate. If symptoms deteriorate I would like to see him again. In the meantime, I do not think that he should have injections or use nonsteroidal anti-inflammatory agents at present, according to the doctor.

As of February 14, 1994, Dr. W.A. Wainright, also an orthopedic, reported as follows (CX 22-23):

> **HISTORY**: He is an 49 year old who presents with chief complaint of diagnosis of carpal tunnel syndrome.
>
> He has seen multiple health care providers in the past including Donald Kelly in Hartford, The Occupational Health Services of New London. His main complaint today is pain in the neck and shoulder areas. He does have some nighttime paresthesias. He has morning stiffness.
>
> On reviewing his medical records, he did present to OHS on May 10, 1993. He is employed at Electric Boat as a sheetmetal worker and according to his notes, uses pneumatic tools two to three hours a day.

Nerve testing was done which showed bilateral carpal tunnel syndrome. Plethysmography was interpreted as normal.

He was seen in follow-up on June 24th and treated with anti-vibration gloves and wrist splints. Neck discomfort was noted as well.

He was seen again in follow-up on September 3rd. He was seen for an Independent Medical Exam by Dr. Kelly on October 21st. Diagnosis was bilateral carpal tunnel syndrome.

EXAM: Today on examination, he does have decreased range of motion of the cervical spine. Thoracic outlet stressing is negative. There is tenderness over the ulnar nerve in the cubital tunnel bilaterally. Flexion test is mildly positive at the elbow. There is a mildly positive Tinel sign. Phalen's test is positive bilaterally as well with quick rise of paresthesias on the left and the right.

IMPRESSION: Bilateral carpal tunnel syndrome.

Judging from his medical records, this has worsened over the past three or four months as his physical findings are now more positive.

He is having marked cervical complaints and I would encourage him to see a physician for evaluation and treatment of his problems.

I'd be glad to see him back here if the symptoms in the hand worsen.

He does not have thenar or intrinsic weakness in the hands today. He does not have continued paresthesias.

Because of the above facts, he is not a candidate for surgical release of his carpal tunnels on a medical basis. Most patients come to carpal tunnel release because of their symptomatology and not because of there (sic) findings and the patient may, indeed, be worsening and may require carpal tunnel release in the future, according to the doctor.

As of December 12, 1994, Dr. Masterson opined as follows (CX 22-16):

With respect to permanency as far as Mr. Talar's cervical spine is concerned, please be advised at the present time I would feel he has a 10% loss of use of the cervical spine as a sequel of a neck injury sustained in and out of the course of his employment at the Electric Boat, according to the doctor.

As of December 13, 1999, Dr. Browning reported as follows (CX 22-3):

12/13/99 Patient returns. His shoulder injury is 10/30/97, OWCP #01-142216. Apparently Willetts, on page 7, gave him about 6%. The neck was paid in 1998.

He apparently had much work with asbestos, and he has been referred to Dr. Bigos, and he apparently has some spots or abnormality on his chest x-ray, and this should be followed up by Dr. Bigos.

He's now age 55 with 34 years in.

He's short of breath. The shoulders grind, left greater than right. The AC joint shows changes on the x-ray. No definite changes or tenderness over the long bead of the biceps on the right. He has discomfort if the arm is raised to 90^0.

This gentleman also has ulcerative colitis. His doctor for that is Dr. Alan Greenwald and Dr. Suzanne Klokotka.

I would suggest a 5% rating on each shoulder up the present time, according to the doctor.

As of January 31, 2000, Dr. Browning reported as follows (CX 22-2):

Please change the rating of 5% to each shoulder to 5% to each upper extremity. I should have made it to the upper extremity in the first place, and I'm sorry I didn't.

Claimant's hearing problems are reported in the January 6, 1998 letter of Dr. Peter J. Rosenberg, an otolaryngologist (CX 23):

This patient had an evaluation by me with audiogram in February of 1994 and in November of 1995. He returns to this office for further evaluation. The patient continues to work at the Electric Boat Company as s sheetmetal worker. He is exposed to the noise of heavy machinery, grinding, shears, saws and hammers. He does wear ear protectors. The patient has had follow-up audiograms at the Electric Boat Company and apparently has had some progression of hearing loss left ear greater than right. It is for further documentation and evaluation of his hearing loss that the patient returns to the office.

The patient did fire weapons 30 years ago but has no other known noise exposure in recent years. He has not had any ear discharge and he has no ear pain. He is not bothered by tinnitus and does not have a problem with vertigo.

On examination we have a husky heavy set gentleman with a receding hairline. He appears to be in good health. He does take Lomotil and Sulfadine for an ulcerative colitis problem that he has had for the past 20 years. The ear canals and tympanic membranes are normal. The nasal passageways are clear. Mouth and oropharynx

unremarkable. The neck supple, no masses, no adenopathy noted.

Today's audiogram was performed by Martha D'Amato, certified clinical audiologist, using our Grason Stadler audiometer calibrated in September of 1997 to the ANSI 1969 standards. This audiogram does reveal a bilateral mild sloping to moderately severe high frequency sensorineural hearing loss between 2000 and 8000 Hertz. There has been a slight progression of this hearing loss compared to the audiogram obtained in November of 1995. At that time this patient had a 0% binaural impairment. This time using the AMA formulation for the determination of percentage impairment, this office calculates a 7.5% loss for the left ear, 5.63% loss for the right ear with a 5.94% binaural hearing loss. The patient was noted to have decreased discrimination scores to 52% when there is background noise.

Impression is that of a long history of noise induced hearing loss. Recommend consideration for a hearing aid evaluation and trial period of amplification and of course use of ear protectors when exposed to hazardous noise. The patient plans to have a re-evaluation of his hearing every one to two years, according to the doctor.

The Employer, faced with that medical evidence presented by the Claimant, defends the claim on the basis of the February 3, 1999 and January 31, 2001 reports of Dr. Daniel A. Gerardi (RX 2, RX 5), the March 20, 2002 report of Dr. Philo Willetts (RX 8) and the Labor Market Surveys of Jennifer Vanderleeden dated March 16, 2001 (RX 6) and April 15, 2002 (RX 10), and these reports will now be discussed.

Dr. Daniel A. Gerardi, after the usual social and employment history reports, his review of Claimant's diagnostic tests and the physical examination, took the following **Occupational History** (RX 2):

OCCUPATIONAL HISTORY: 1961 - The patient left high school in his junior year to join the *United States Marine Corps* but apparently failed the entrance physical examination because of a heart murmur and then began work as a clerk in the General Store in Norwich, Connecticut.

July 1962 - 1967 - *The Electric Boat Shipyard*. He was a sheet metal worker installing duct work, doors and bulkheads primarily on newer constructed submarines occasionally with overhaul vessels as well. Most of the work was done inside the boat in small confined areas and he worked adjacent to laggers and pipe fitters and there was a significant amount of asbestos in the air and dust covering the materials with which they worked. He used to make heater strips out of asbestos as well as sound dampening plates and gaskets which were punched through asbestos sheets. Asbestos blankets and protective devices were used also. Asbestos work

would not occur on a daily basis but he described it as very frequent. No protective gear was worn during this time. Being a young individual looking for extra work he worked forty to sixty hours a week at a minimum and tried to get as much overtime as possible. He was laid off.

1967 - Approximately 1968 - *Coca Cola Company* in New London. He was a truck driver and delivery person.

1968 - 1969 - *Atlas Builders*, Franklin, Connecticut. He worked in construction doing residential roofing and carpentry work.

1969 - 1971 - *Electric Boat Shipyard*. He was involved in overhaul work ripping out parts and destroying areas of the ship that needed to be redone. He worked throughout the boat. He was unclear how much asbestos he was exposed to in this work environment but he described it as a very dusty dirty environment and again did not use protective devices. His work hours were the same as his prior Electric Boat a minimum of forty to sixty hours per week and perhaps longer.

1971 - *AMF Company* until the company moved to a southern location.

1971 - Approximately 1972 - *Maple Shade Dairy*, Guilford, Connecticut. He drove a milk delivery truck.

1973 - Present - *Electric Boat Shipyard*. He is involved now primarily in sheet metal work and worked in the ship making ducts, primarily from stainless steel, but also aluminum and steel. He would occasionally work with welders but most of this was a cleaner environment than working within the submarine, as he did primarily shop work and since 1989 has not been on the boats themselves. This accommodation was apparently made because of his development of ulcerative colitis and the requirement of access to restroom facilities. For the last eighteen years he has been making pipe covers to put on pipes that had previously been lagged. He worked on both the Trident and the Seawolf submarines and again was using mostly stainless steel. He was exposed to some solvents such as acetone and others that were required to clean the metal surfaces, and he was also exposed to spot welding and the fumes that that produced. Currently for the last three months he describes his position as a ship fitter.

He had one significant injury during this time at the Electric boat on 12/24/73, a metal sliver was sent into his right eye as he was walking through the shop and he has had complete loss of vision. This was enucleated in 1976 to protect the vision in his remaining eye...

Dr. Gerardi concluded as follows (**Id.**):

IMPRESSIONS:

1. Bilateral pleural plaque disease, calcified, consistent with remote asbestos exposure.

2. Obstructive sleep apnea syndrome and periodic leg movement disorder.

3. Ulcerative colitis, long standing with history of multiple polypectomies.

4. Erythrocytosis - relative, without evidence for polysythemia vera.

5. Hypertension - essential - unconfirmed.

6. Left eye enucleation secondary to trauma.

7. Obesity, mild, exogenous.

8. History of nephrolethiasis.

COMMENTS AND RECOMMENDATIONS: Mr. William Talar has had a significant exposure to asbestos with a subsequent development of bilateral calcified pleural and diaphragmatic plaques. Based on the history that I have obtained today it would seem most likely that this is causally related to his work for the Electric Boat Shipyard in the 1960's where he was exposed to asbestos in the construction and renovation of submarines.

Fortunately his disease is limited currently to the development of pleural disease and there is no current evidence for fibrosis, cancer or mesothelioma related to this exposure. A biopsy done recently, throscopically, was of pleural plaque disease and was benign. In reviewing the records up to the time of the biopsy, the surgery was performed to rule out pleural mesothelioma given apparent asymmetric disease and because of a very perplexing radiology report. As I mentioned there is no evidence of malignancy in this patient but pleural disease can often begin asymmetrically depending on when it is diagnosed and most frequently is found to affect the central tendon of the diaphragm producing the plaque that was noted. In addition the CT scan preoperatively I believe is most suggestive of early changes related to rounded atelectasis and not focal fibrosis. Also, this patient has not been a smoker which reduces his risk for development of lung cancer in the setting of asbestos exposure. In fact in regard to development of cancer in this patient I would be more concerned about the development of colon cancer given his family history, and his own history of ulcerative cholitis with polyps.

It is difficult to determine a specific impairment based on the above listed disease. Pulmonary function studies done today revealed a restrictive lung disease out of proportion to the degree

of pleural disease noted of certainly in part appropriate for the degree of obesity. In addition there are still likely restrictive changes related to his surgery and he has not reached maximum recovery from the thorascopic surgery in terms of his pulmonary functions. If specific impairment would be required I would suggest a repeat pulmonary function study in approximately four months to look for stabilization of the pulmonary function values and a more specific impairment. In addition weight loss which would assist likely in his sleep apnea as well as the restriction related to obesity and the pulmonary function study, would also serve to affect his maximum medical improvement. If needed currently I would estimate his impairment to be 15% for both lungs and the whole person, based on the **AMA Guide to the Evaluation of Respiratory Impairment**, 4th Edition 1993, equally divided between restrictive changes related to obesity and those related to the recent thorascopic surgery. I also suggest, of course, that he be followed periodically with pulmonary function studies and perhaps radiographically for the development of any further manifestations of asbestos related disease. He is currently seeing very experienced pulmonologist in Dr. Bigos to this end, according to the doctor.

As of April 3, 1999, John A. Kennedy, B.C.O., of American Optical Lens Company, sent the following letter to the Employer (RX 3):

FROM: American Optical Lens Company, Prosthetic Eye Center

DATE: 4-3-99

SUBJECT: PT:Talar, Wm., Accident Date - 12-24-74
Case Number - none available

NO OF PAGES, INCL. THIS ONE: 1

COMMENTS: We have scheduled an appointment on 7-15-99 for Mr. William Talar for a new right Ocular Prosthesis.

He is wearing a prosthesis which is over eight years old and a replacement is recommended.

CRT Code V2623
Diagnosis Code 871.3
Our fee is $1,100.00

If you have any questions please contact us.

Dr. Gerardi re-examined Claimant on January 31, 2001 and he sent the following letter to the Employer, the doctor concluding as follows (RX 5):

IMPRESSIONS:

1. Bilateral pleural plaque disease, with evidence for calcification and rounded atelectasis. There is no evidence for asbestosis, pulmonary fibrosis.

2. Atopic disease and mild airflow obstruction.

3. Obstructive sleep apnea with periodic limb movement disorder.

4. Obesity, exogenous, mild.

5. Ulcerative colitis, long standing, controlled.

6. Hypertension, essential, treated.

7. Left eye enucleation, traumatic.

8. History of nephrolethiasis.

9. History of polycythemia, resolved, not p-vera.

COMMENTS AND RECOMMENDATIONS: Mr. Talar has evidence of remote asbestos exposure likely related to his employment at The Electric Boat Shipyard. This evidence is in the form of bilateral calcified pleural plaques disease that is pathopnemonic for asbestos exposure. He had surgery that has proven this regard. In addition there is evidence of rounded atelectasis at the left base. All of these findings are however, unchanged from his prior evaluation in 1999, as evidenced on physical examination and radiographically. There is no evidence for the development of asbestosis, that is pulmonary fibrosis, related to his asbestos exposure, nor is there evidence for the development of any asbestos related malignancy.

Over the last few years Mr. Talar seems to have an increase in his symptoms primarily with persistent shortness of breath with exertion, intermittent chest tightness and wheezing, and a cough that is fairly regular and productive. His history is now more demonstrable for atopic disease particularly with an environmental allergy likely in the autumn months. Further there is evidence for demonstration of mild airflow obstruction based on his pulmonary function study although he has an improvement in his vital capacity. There is no demonstrated reversibility on his pulmonary function study today but with treatment his value may improve somewhat to more normal levels. As evidenced this may represent latent asthma given his history of atopic disease. I do not see obvious direct connection between his workplace. Looking back he did complain of shortness of breath as early as 1987 when at this time he may having intermittent airway disease that is only more recently brought out by pulmonary function study and history. The airway disease is quite mild. I also wonder however about the contribution of his ACE inhibitor to his cough given that this is

a new medication although it is two years and this symptom has almost appeared during that time span.

Mr. Talar is however mildly obese although he has lost nine pounds since his previous evaluation. His pulmonary function study demonstrates a restriction that is related to his obesity and his x-rays demonstrate the reduction in lung volumes also related to his obesity. There is no contribution from his pleural plaques and the development of restriction. His previous thoracotomy is likely only minimally and likely insignificantly contributed to this abnormality.

Therefore, using reasonable medical judgment and **The AMA Guide to the Evaluation of Respiratory Impairment**, 5th addition, 2001, I would ascribe Mr. Talar a 15% impairment to both lungs and the whole person. This would be equally divided with 5% to each respiratory component including obesity, obstructive sleep apnea syndrome, mild airways disease-atopic disease. There is no contribution to his respiratory impairment related to asbestos related lung injury. I do believe that he has reached the point of maximal medical improvement and with some additional weight loss would have improvement in his total lung capacity and reduction in his impairment. The underlying conditions of apnea and obesity for example, would however make any injury attributed to his work capacity, materially and substantially greater than it would have otherwise been. Mr. Talar is capable of light work. His activities as mentioned in the history of present illness include regular riding of a bicycle and activities around the home and a workplace, with a relatively light duty and not extreme physical exertion he would be able to perform light duties if required, according to the doctor.

The Employer has referred Claimant to Dr. Philo F. Willetts, Jr., an orthopedic surgeon, and the doctor sent the following letter to the Employer on March 20, 2002 (RX 8):

I reexamined William Talar in my office today for his complaints of bilateral shoulder pain, said to be of six or seven years' duration, bilateral hand pain and aching, said to be of seven or eight years' duration, and neck pain, said to be of about ten years' duration. Mr. Talar said he previously had had numbness of his hands but no longer did so. William Talar is a 57 year old right-handed sheet metal mechanic who emphasized that he was terminated, not for the above complaints, but for some shortness of breath and lung disorder, for which he was treated in November, 1998. He said he did not recall an injury of October 14, 1997. He was unsure of many of the details of his conditions.

I had previously seen Mr. Talar in August, 1995, for complaints of neck and upper extremity pains, then said to be of several years' duration, and at which time he had difficulty presenting a history. I reviewed the above history with Mr. Talar today, and it is

briefly summarized as follows.

He said that he had had neck soreness for several years and that it had increased in December, 1993. He had seen his family physician, Dr. Basu, and subsequently had been evaluated at the Occupational Health Clinic and been told of bilateral carpal tunnel syndrome with tests negative for vibration white finger. He said that he had been evaluated by Dr. Kelly in Hartford and been advised that he had carpal tunnel syndromes and a neck problem. He had also been evaluated by Dr. Wainright, had undergone electrical diagnostic tests, and said he was told of carpal tunnel syndrome. He was treated by Dr. Masterson for his neck and subsequently by Dr. Glenney.

Since I have last seen Mr. Talar in August, 1995, he said that he had continued working full duty. He said that, in November, 1998, he became increasingly short of breath and treated with Dr. Bigos and Dr. Darren. He said that he underwent a biopsy of the left lung, was diagnosed as having asbestosis pleural plaques but no malignancy. He said he was put out of work because of his lungs and eventually was terminated 18 months ago because of his inability to return to full duty.

He said that Attorney Spayne sent him to Dr. Browning in about 1997 or 1998. He said he was also sent for vascular tests, blood tests, and electrical diagnostic tests. He said that he recalled seeing Dr. Wainright since I had last seen him as well.

He said that he no longer treated with anyone for any neck, shoulder, or upper extremity symptoms. He said that he did do exercise and took Naproxen once per day. He said that he no longer had numbness of his hands since being off work but was otherwise unchanged.

He said that he had neck pain that would increase with rotation, extension, lifting, and had shoulder pain that would increase by motion in all planes. He said he got relief from avoiding the above and using heat.

He denied having any upper extremity numbness. He said that he had some pain but no actual weakness of the upper extremities. He later said he did have rare tingling of the left fingers.

He said that, in the early 1990's, he carried a 100 pound safe down the stairs and noted neck pain. He was unaware of other injuries. He said that he had never been involved in any motor vehicle accidents. He denied having any chest pain or cardiac signs.

He said that he did not awaken with numbness. He denied having any white, blanched, or discolored fingers, in the cold or otherwise.

He said that he had increased hand pain with gripping, writing,

lifting, using tools, and in cold weather. He said he got relief from rest, heat, shaking the hand, and hanging it down.

WORK STATUS: He said that he had worked full duty until being put out of work for asbestosis.

DIAGNOSIS:

1. Long preexisting degenerative arthritis cervical spine.

2. Impingement syndrome both shoulders, with no sign of surgical rotator cuff disease.

3. Mild bilateral carpal tunnel syndromes, with positive electrical studies but normal neurological evaluation.

4. No sign of vibration white finger.

DISCUSSION: I will try to respond to your questions in order as follows.

1. PROGNOSIS is for probably continued symptoms at about the same level. Mr. Talar said that he had improved his numbness significantly since stopping work, and it is possible, therefore, that he might improve further.

2. HISTORY OF INJURY & SUBSEQUENT MEDICAL TREATMENT: Please note above history of injury and subsequent medical treatment.

3. PRIOR INJURIES AND/OR PREEXISTING CONDITIONS: He had, unfortunately, lost his right eye in 1975 as a result of a work injury at Electric Boat Corporation. He also has had ulcerative colitis for many years and may have the inflammatory arthritis associated with that. He has had long preexisting degenerative arthritis of the cervical spine. He has had chronic obesity. In addition, Mr. Talar was diagnosed by Dr. Moalli, as early as June 4, 1993, with bilateral carpal tunnel syndromes. He had injured his left shoulder July 29, 1989. He had apparently developed increased neck pain in 1990 when carrying a 100 pound safe down the stairs.

4. CAUSAL RELATIONSHIP TO INJURY: The degenerative arthritis of the cervical spine was predominantly preexisting. A safe carrying episode of 1990 or 1991 may have aggravated his neck pain.

The bilateral carpal tunnel syndromes were probably contributed to by his sheet metal work which involved hand rolling of sheet metal over the years. The improvement in some of his symptoms, especially with decreased numbness, also reflects a contribution of work to his carpal tunnel syndromes.

The left shoulder sustained an injury in 1989, as described above, and has been contributed to by his work activities over the years.

Probably, his right shoulder has been contributed to by his work activities.

5. *Further treatment needed? If so, what kind? How long?*

I do not believe that Mr. Talar requires any formal treatment for his complaints. Now that he has been retired, his hand symptoms have somewhat decreased. There are no significant surgical indications for his carpal tunnels. There are no surgical indications for his shoulders either. Nor is there any indication for operation for the cervical spine.

An exercise program and occasional anti-inflammatories are the only treatment (that would be) appropriate.

6. *Can claimant return to work at this time? If not, time frame for same; if so, in what capacity? Any restrictions?*

Mr. Talar emphasized that he was working full duty prior to being put out of work for his unrelated lung problems. He said that he was terminated for inability to return to full duty based on his lungs, not for the problems for which I examined him today. He could return to his normal duty with respect to his neck, shoulder, and upper extremity problems. He could return to that work without restriction and without hazard to his health with respect to his neck and upper extremities.

7. *What are claimant's physical capabilities? Be specific.*

Mr. Talar can do the full duties of sheet metal mechanic with respect to his neck, shoulders, and upper extremities. He is presumably limited because of his pulmonary compromise, a condition that is outside of this examiner's expertise, according to the doctor.

Should you have any further questions or require additional information, please do not hesitate to contact this office.

The respective vocational rehabilitation reports will be discussed below in the section dealing with disability.

On the basis of the totality of this record and having observed the demeanor and heard the testimony of a credible Claimant, I make the following:

Findings of Fact and Conclusions of Law

This Administrative Law Judge, in arriving at a decision in this matter, is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it, and he is not bound to accept the opinion or theory of any particular medical examiner. **Banks v. Chicago Grain Trimmers**

Association, Inc., 390 U.S. 459 (1968), **reh. denied**, 391 U.S. 929 (1969); **Todd Shipyards v. Donovan**, 300 F.2d 741 (5th Cir. 1962); **Scott v. Tug Mate, Incorporated**, 22 BRBS 164, 165, 167 (1989); **Hite v. Dresser Guiberson Pumping**, 22 BRBS 87, 91 (1989); **Anderson v. Todd Shipyard Corp.**, 22 BRBS 20, 22 (1989); **Hughes v. Bethlehem Steel Corp.**, 17 BRBS 153 (1985); **Seaman v. Jacksonville Shipyard, Inc.**, 14 BRBS 148.9 (1981); **Brandt v. Avondale Shipyards, Inc.**, 8 BRBS 698 (1978); **Sargent v. Matson Terminal, Inc.**, 8 BRBS 564 (1978).

The Act provides a presumption that a claim comes within its provisions. **See** 33 U.S.C. §920(a). This Section 20 presumption "applies as much to the nexus between an employee's malady and his employment activities as it does to any other aspect of a claim." **Swinton v. J. Frank Kelly, Inc.**, 554 F.2d 1075 (D.C. Cir. 1976), **cert. denied**, 429 U.S. 820 (1976). Claimant's uncontradicted credible testimony alone may constitute sufficient proof of physical injury. **Golden v. Eller & Co.**, 8 BRBS 846 (1978), **aff'd**, 620 F.2d 71 (5th Cir. 1980); **Hampton v. Bethlehem Steel Corp.**, 24 BRBS 141 (1990); **Anderson v. Todd Shipyards**, **supra**, at 21; **Miranda v. Excavation Construction, Inc.**, 13 BRBS 882 (1981).

However, this statutory presumption does not dispense with the requirement that a claim of injury must be made in the first instance, nor is it a substitute for the testimony necessary to establish a "**prima facie**" case. The Supreme Court has held that "[a] **prima facie** 'claim for compensation,' to which the statutory presumption refers, must at least allege an injury that arose in the course of employment as well as out of employment." **United States Indus./Fed. Sheet Metal, Inc., v. Director, Office of Workers' Compensation Programs, U.S. Dep't of Labor**, 455 U.S. 608, 615 102 S. Ct. 1318, 14 BRBS 631, 633 (CRT) (1982), **rev'g Riley v. U.S. Indus./Fed. Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). Moreover, "the mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." U.S. Industries/Federal Sheet Metal, Inc., et al., v. Director, Office of Workers' Compensation Programs, U.S. Department of Labor, 455 U.S. 608, 102 S.Ct. 1318 (1982), **rev'g Riley v. U.S. Industries/Federal Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). The presumption, though, is applicable once claimant establishes that he has sustained an injury, **i.e.**, harm to his body. **Preziosi v. Controlled Industries**, 22 BRBS 468, 470 (1989); **Brown v. Pacific Dry Dock Industries**, 22 BRBS 284, 285 (1989); **Trask v. Lockheed Shipbuilding and Construction Company**, 17 BRBS 56, 59 (1985); **Kelaita v. Triple A. Machine Shop**, 13 BRBS 326 (1981).

To establish a **prima facie** claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that (1) the claimant sustained physical harm or pain and (2) an accident occurred in the course of employment, or conditions

existed at work, which could have caused the harm or pain. **Kelaita**, **supra**; **Kier v. Bethlehem Steel Corp.**, 16 BRBS 128 (1984). Once this **prima facie** case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. To rebut the presumption, the party opposing entitlement must present substantial evidence proving the absence of or severing the connection between such harm and employment or working conditions. **Kier**, **supra**; **Parsons Corp. of California v. Director, OWCP**, 619 F.2d 38 (9th Cir. 1980); **Butler v. District Parking Management Co.**, 363 F.2d 682 (D.C. Cir. 1966); **Ranks v. Bath Iron Works Corp.**, 22 BRBS 301, 305 (1989). Once claimant establishes a physical harm and working conditions which could have caused or aggravated the harm or pain the burden shifts to the employer to establish that claimant's condition was not caused or aggravated by his employment. **Brown v. Pacific Dry Dock**, 22 BRBS 284 (1989); **Rajotte v. General Dynamics Corp.**, 18 BRBS 85 (1986). If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. **Del Vecchio v. Bowers**, 296 U.S. 280 (1935); **Volpe v. Northeast Marine Terminals**, 671 F.2d 697 (2d Cir. 1981). In such cases, I must weigh all of the evidence relevant to the causation issue. **Sprague v. Director, OWCP**, 688 F.2d 862 (1st Cir. 1982); **MacDonald v. Trailer Marine Transport Corp.**, 18 BRBS 259 (1986).

The U.S. Court of Appeals for the First Circuit has considered the Employer’s burden of proof in rebutting a **prima facie** claim under Section 20(a) and that Court has issued a most significant decision in **Bath Iron Works Corp. v. Director, OWCP (Shorette)**, 109 F.3d 53, 31 BRBS 19(CRT)(1st Cir. 1997).

In **Shorette**, the United States Court of Appeals for the First Circuit, in whose jurisdiction this case arises, held that an employer need not rule out any possible causal relationship between a claimant’s employment and his condition in order to establish rebuttal of the Section 20(a) presumption. The court held that employer need only produce substantial evidence that the condition was not caused or aggravated by the employment. **Id**., 109 F.3d at 56,31 BRBS at 21 (CRT); **see also Bath Iron Works Corp. v. Director, OWCP [Harford]**, 137 F.3d 673, 32 BRBS 45 (CRT)(1st Cir. 1998). The court held that requiring an employer to rule out any possible connection between the injury and the employment goes beyond the statutory language presuming the compensability of the claim “in the absence of substantial evidence to the contrary.” 33 U.S.C. §920(a). **See Shorette,** 109 F.3d at 56, 31 BRBS at 21 (CRT). The “ruling out” standard was recently addressed and rejected by the Court of Appeals for the Fifth and Seventh Circuits as well. **Conoco, Inc. v. Director, OWCP [Prewitt]**, 194 F.3d 684, 33 BRBS 187(CRT)(5th Cir. 1999); **American Grain Trimmers, Inc. v. OWCP**, 181 F.3d 810, 33 BRBS 71(CRT)(7th Cir. 1999); **see also O’Kelley v. Dep’t of the Army/NAF**, 34 BRBS 39 (2000); **but see Brown v. Jacksonville Shipyards, Inc.**, 893 F.2d 294, 23 BRBS 22 (CRT)(11th Cir. 1990) (affirming the finding that the Section 20(a)

presumption was not rebutted because no physician expressed an opinion "ruling out the possibility" of a causal relationship between the injury and the work).

To establish a **prima facie** case for invocation of the Section 20(a) presumption, claimant must prove that (1) he suffered a harm, and (2) an accident occurred or working conditions existed which could have caused the harm. **See**, **e.g.**, **Noble Drilling Company v. Drake**, 795 F.2d 478, 19 BRBS 6 (CRT) (5th Cir. 1986); **James v. Pate Stevedoring Co.**, 22 BRBS 271 (1989). If claimant's employment aggravates a non-work-related, underlying disease so as to produce incapacitating symptoms, the resulting disability is compensable. **See Rajotte v. General Dynamics Corp.**, 18 BRBS 85 (1986); **Gardner v. Bath Iron Works Corp.**, 11 BRBS 556 (1979), **aff'd sub nom. Gardner v. Director, OWCP**, 640 F.2d 1385, 13 BRBS 101 (1st Cir. 1981). If employer presents substantial evidence sufficient to sever the connection between claimant's harm and his employment, the presumption no longer controls, and the issue of causation must be resolved on the whole body of proof. **See**, **e.g.**, **Leone v. Sealand Terminal Corp.**, 19 BRBS 100 (1986).

The Board has held that credible complaints of subjective symptoms and pain can be sufficient to establish the element of physical harm necessary for a **prima facie** case for Section 20(a) invocation. **See Sylvester v. Bethlehem Steel Corp.**, 14 BRBS 234, 236 (1981), **aff'd**, 681 F.2d 359, 14 BRBS 984 (5th Cir. 1982). Moreover, I may properly rely on Claimant's statements to establish that he/she experienced a work-related harm, and as it is undisputed that a work accident occurred which could have caused the harm, the Section 20(a) presumption is invoked in this case. **See**, **e.g.**, **Sinclair v. United Food and Commercial Workers**, 23 BRBS 148, 151 (1989). Moreover, Employer's general contention that the clear weight of the record evidence establishes rebuttal of the pre-presumption is not sufficient to rebut the presumption. **See generally Miffleton v. Briggs Ice Cream Co.**, 12 BRBS 445 (1980).

The presumption of causation can be rebutted only by "substantial evidence to the contrary" offered by the employer. 33 U.S.C. § 920. What this requirement means is that the employer must offer evidence which completely **rules out the** connection between the alleged event and the alleged harm. In **Caudill v. Sea Tac Alaska Shipbuilding**, 25 BRBS 92 (1991), the carrier offered a medical expert who testified that an employment injury did not "play a significant role" in contributing to the back trouble at issue in this case. The Board held such evidence insufficient as a matter of law to rebut the presumption because the testimony did not completely rule out the role of the employment injury in contributing to the back injury. **See also Cairns v. Matson Terminals, Inc.**, 21 BRBS 299 (1988) (medical expert opinion which did entirely attribute the employee's condition to non-work-related factors was nonetheless insufficient to rebut the presumption where the expert equivocated somewhat on causation elsewhere in his

testimony). Where the employer/carrier can offer testimony which completely severs the causal link, the presumption is rebutted. **See Phillips v. Newport News Shipbuilding & Dry Dock Co.**, 22 BRBS 94 (1988) (medical testimony that claimant's pulmonary problems are consistent with cigarette smoking rather than asbestos exposure sufficient to rebut the presumption).

For the most part only medical testimony can rebut the Section 20(a) presumption. **But see Brown v. Pacific Dry Dock**, 22 BRBS 284 (1989) (holding that asbestosis causation was not established where the employer demonstrated that 99% of its asbestos was removed prior to the claimant's employment while the remaining 1% was in an area far removed from the claimant and removed shortly after his employment began). Factual issues come in to play only in the employee's establishment of the **prima facie** elements of harm/possible causation and in the later factual determination once the Section 20(a) presumption passes out of the case.

Once rebutted, the presumption itself passes completely out of the case and the issue of causation is determined by examining the record "as a whole". **Holmes v. Universal Maritime Services Corp.**, 29 BRBS 18 (1995). Prior to 1994, the "true doubt" rule governed the resolution of all evidentiary disputes under the Act; where the evidence was in equipoise, all factual determinations were resolved in favor of the injured employee. **Young & Co. v. Shea**, 397 F.2d 185, 188 (5th Cir. 1968), **cert. denied,** 395 U.S. 920, 89 S. Ct. 1771 (1969). The Supreme Court held in 1994 that the "true doubt" rule violated the Administrative Procedure Act, the general statute governing all administrative bodies. **Director, OWCP v. Greenwich Collieries**, 512 U.S. 267, 114 S. Ct. 2251, 28 BRBS 43 (CRT) (1994). Accordingly, after **Greenwich Collieries** the employee bears the burden of proving causation by a preponderance of the evidence after the presumption is rebutted.

As neither party now disputes that the Section 20(a) presumption is invoked, **see Kelaita v. Triple A Machine Shop**, 13 BRBS 326 (1981), the burden shifts to employer to rebut the presumption with substantial evidence which establishes that claimant's employment did not cause, contribute to, or aggravate his condition. **See Peterson v. General Dynamics Corp.**, 25 BRBS 71 (1991), **aff'd sub nom. Insurance Company of North America v. U.S. Dept. of Labor**, 969 F.2d 1400, 26 BRBS 14 (CRT)(2d Cir. 1992), **cert. denied,** 507 U.S. 909, 113 S. Ct. 1264 (1993); **Obert v. John T. Clark and Son of Maryland,** 23 BRBS 157 (1990); **Sam v. Loffland Brothers Co.**, 19 BRBS 228 (1987). The unequivocal testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. **See Kier v. Bethlehem Steel Corp.**, 16 BRBS 128 (1984). If an employer submits substantial countervailing evidence to sever the connection between the injury and the employment, the Section 20(a) presumption no longer controls and the issue of causation must be resolved on the whole body of proof. **Stevens v. Tacoma**

Boatbuilding Co., 23 BRBS 191 (1990). This Administrative Law Judge, in weighing and evaluating all of the record evidence, may place greater weight on the opinions of the employee's treating physician as opposed to the opinion of an examining or consulting physician. In this regard, **see Pietrunti v. Director, OWCP**, 119 F.3d 1035, 31 BRBS 84 (CRT)(2d Cir. 1997). **See also Amos v. Director, OWCP,** 153 F.3d 1051 (9th Cir. 1998), **amended,** 164 F.3d 480, 32 BRBS 144 (CRT) (9th Cir. 1999), **cert. denied**, 120 S.Ct. 40 (1999).

In the case **sub judice**, Claimant alleges that the harm to his bodily frame, **i.e.**, his asbestosis and his chronic obstructive pulmonary disease, resulted from his exposure to and inhalation of asbestos at the Employer's shipyard. The Employer has not introduced substantial evidence severing the connection between such harm and Claimant's maritime employment. In this regard, **see Romeike v. Kaiser Shipyards**, 22 BRBS 57 (1989). Thus, Claimant has established a **prima facie** claim that such harm is a work-related injury, as shall now be discussed.

Injury

The term "injury" means accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury. **See** 33 U.S.C. §902(2); **U.S. Industries/Federal Sheet Metal, Inc., et al., v. Director, Office of Workers Compensation Programs, U.S. Department of Labor**, 455 U.S. 608, 102 S.Ct. 1312 (1982), **rev'g Riley v. U.S. Industries/Federal Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). A work-related aggravation of a pre-existing condition is an injury pursuant to Section 2(2) of the Act. **Gardner v. Bath Iron Works Corporation**, 11 BRBS 556 (1979), **aff'd sub nom. Gardner v. Director, OWCP**, 640 F.2d 1385 (1st Cir. 1981); **Preziosi v. Controlled Industries**, 22 BRBS 468 (1989); **Januszie wicz v. Sun Shipbuilding and Dry Dock Company**, 22 BRBS 376 (1989) (**Decision and Order on Remand**); **Johnson v. Ingalls Shipbuilding**, 22 BRBS 160 (1989); **Madrid v. Coast Marine Construction**, 22 BRBS 148 (1989). Moreover, the employment-related injury need not be the sole cause, or primary factor, in a disability for compensation purposes. Rather, if an employment-related injury contributes to, combines with or aggravates a pre-existing disease or underlying condition, the entire resultant disability is compensable. **Strachan Shipping v. Nash**, 782 F.2d 513 (5th Cir. 1986); **Independent Stevedore Co. v. O'Leary**, 357 F.2d 812 (9th Cir. 1966); **Kooley v. Marine Industries Northwest**, 22 BRBS 142 (1989); **Mijangos v. Avondale Shipyards, Inc.**, 19 BRBS 15 (1986); **Rajotte v. General Dynamics Corp.**, 18 BRBS 85 (1986). Also, when claimant sustains an injury at work which is followed by the occurrence of a subsequent injury or aggravation outside work, employer is liable for the entire disability if that subsequent injury is the natural and

unavoidable consequence or result of the initial work injury. **Bludworth Shipyard, Inc. v. Lira**, 700 F.2d 1046 (5th Cir. 1983); **Mijangos**, **supra**; **Hicks v. Pacific Marine & Supply Co.**, 14 BRBS 549 (1981). The term injury includes the aggravation of a pre-existing non-work-related condition or the combination of work- and non-work-related conditions. **Lopez v. Southern Stevedores**, 23 BRBS 295 (1990); **Care v. WMATA**, 21 BRBS 248 (1988).

In occupational disease cases, there is no "injury" until the accumulated effects of the harmful substance manifest themselves and claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should become have been aware, of the relationship between the employment, the disease and the death or disability. **Travelers Insurance Co. v. Cardillo**, 225 F.2d 137 (2d Cir. 1955), **cert. denied**, 350 U.S. 913 (1955). **Thorud v. Brady-Hamilton Stevedore Company, et al.**, 18 BRBS 232 (1987); **Geisler v. Columbia Asbestos, Inc.**, 14 BRBS 794 (1981). Nor does the Act require that the injury be traceable to a definite time. The fact that claimant's injury occurred gradually over a period of time as a result of continuing exposure to conditions of employment is no bar to a finding of an injury within the meaning of the Act. **Bath Iron Works Corp. v. White**, 584 F.2d 569 (1st Cir. 1978).

This closed record conclusively establishes, and I so find and conclude, that Claimant’s daily exposure to asbestos and other injurious pulmonary stimuli and his frequent use of pneumatic vibratory tools have directly produced his asbestosis and his COPD and his bilateral carpal tunnel syndrome, that the Employer had timely notice of such injuries, that the Employer has authorized certain medical treatment for Claimant, has paid compensation benefits for those time periods reflected on JX 1, timely controverted his entitlement to further benefits and that Claimant timely filed for benefits once a dispute arose between the parties. In fact, the only issue herein is the nature and extent of his disability, an issue I shall now resolve.

Nature and Extent of Disability

It is axiomatic that disability under the Act is an economic concept based upon a medical foundation. **Quick v. Martin**, 397 F.2d 644 (D.C. Cir. 1968); **Owens v. Traynor**, 274 F. Supp. 770 (D.Md. 1967), **aff'd**, 396 F.2d 783 (4th Cir. 1968), **cert. denied**, 393 U.S. 962 (1968). Thus, the extent of disability cannot be measured by physical or medical condition alone. **Nardella v. Campbell Machine, Inc.**, 525 F.2d 46 (9th Cir. 1975). Consideration must be given to claimant's age, education, industrial history and the availability of work he can perform after the injury. **American Mutual Insurance Company of Boston v. Jones**, 426 F.2d 1263 (D.C. Cir. 1970). Even a relatively minor injury may lead to a finding of total disability if it prevents the employee from engaging in the only type of gainful employment for which he is qualified. (**Id**. at 1266)

Claimant has the burden of proving the nature and extent of his disability without the benefit of the Section 20 presumption. **Carroll v. Hanover Bridge Marina**, 17 BRBS 176 (1985); **Hunigman v. Sun Shipbuilding & Dry Dock Co.**, 8 BRBS 141 (1978). However, once claimant has established that he is unable to return to his former employment because of a work-related injury or occupational disease, the burden shifts to the employer to demonstrate the availability of suitable alternative employment or realistic job opportunities which claimant is capable of performing and which he could secure if he diligently tried. **New Orleans (Gulfwide) Stevedores v. Turner**, 661 F.2d 1031 (5th Cir. 1981); **Air America v. Director**, 597 F.2d 773 (1st Cir. 1979); **American Stevedores, Inc. v. Salzano**, 538 F.2d 933 (2d Cir. 1976); **Preziosi v. Controlled Industries**, 22 BRBS 468, 471 (1989); **Elliott v. C & P Telephone Co.**, 16 BRBS 89 (1984). While Claimant generally need not show that he has tried to obtain employment, **Shell v. Teledyne Movible Offshore, Inc.**, 14 BRBS 585 (1981), he bears the burden of demonstrating his willingness to work, **Trans-State Dredging v. Benefits Review Board**, 731 F.2d 199 (4th Cir. 1984), once suitable alternative employment is shown. **Wilson v. Dravo Corporation**, 22 BRBS 463, 466 (1989); **Royce v. Elrich Construction Company**, 17 BRBS 156 (1985).

Moreover, although a claimant relocates for personal reasons, employer can still meet its burden of establishing suitable alternate employment if it shows that such jobs are available within the geographical area in which claimant resided at the time of the injury. **McCullough v. Marathon LeTourneau Company**, 22 BRBS 359, 366 (1989); **Dixon v. John J. McMullen and Associates**, 19 BRBS 243 (1986); **Elliott v. C & P Telephone Co.**, 16 BRBS 89 (1984).

Sections 8(a) and (b) and Total Disability

A worker entitled to permanent partial disability for an injury arising under the schedule may be entitled to greater compensation under Sections 8(a) and (b) by a showing that he/she is totally disabled. **Potomac Electric Power Co. v. Director**, 449 U.S. 268 (1980) (herein "**Pepco**"). **Pepco**, 449 U.S. at 277, n.17; **Davenport v. Daytona Marine and Boat Works**, 16 BRBS 1969, 199 (1984). However, unless the worker is totally disabled, he is limited to the compensation provided by the appropriate schedule provision. **Winston v. Ingalls Shipbuilding, Inc.**, 16 BRBS 168, 172 (1984).

Two separate scheduled disabilities must be compensated under the schedules in the absence of a showing of a total disability, and claimant is precluded from (1) establishing a greater loss of wage-earning capacity than the presumed by the Act or (2) receiving compensation benefits under Section 8(c)(21). Since Claimant suffered injuries to more than one member covered by the schedule, he must be compensated under the applicable portion of Sections 8(c)(1) - (20), with the awards running consecutively. **Potomac**

Electric Power Co. v. Director, OWCP, 449 U.S. 268 (1980). In **Brandt v. Avondale Shipyards, Inc.**, 16 BRBS 120 (1984), the Board held that claimant was entitled to two separate awards under the schedule for his work-related injuries to his right knee and left index finger.

On the basis of the totality of this closed record, I find and conclude that Claimant has established he cannot return to any work at the shipyard. The burden thus rests upon the Employer to demonstrate the existence of suitable alternate employment in the area. If the Employer does not carry this burden, Claimant is entitled to a finding of total disability. **American Stevedores, Inc. v. Salzano**, 538 F.2d 933 (2d Cir. 1976); **Southern v. Farmers Export Company**, 17 BRBS 64 (1985). In the case at bar, the Employer did submit evidence as to the availability of suitable alternate employment. **See Pilkington v. Sun Shipbuilding and Dry Dock Company**, 9 BRBS 473 (1978), **aff'd on reconsideration after remand**, 14 BRBS 119 (1981). **See also Bumble Bee Seafoods v. Director, OWCP**, 629 F.2d 1327 (9th Cir. 1980). I therefore find Claimant has a temporary total disability from November 27, 1998 through June 22, 2001, as further discussed below.

Claimant's injury has become permanent. A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. **General Dynamics Corporation v. Benefits Review Board**, 565 F.2d 208 (2d Cir. 1977); **Watson v. Gulf Stevedore Corp.**, 400 F.2d 649 (5th Cir. 1968), **cert. denied**, 394 U.S. 976 (1969); **Seidel v. General Dynamics Corp.**, 22 BRBS 403, 407 (1989); **Stevens v. Lockheed Shipbuilding Co.**, 22 BRBS 155, 157 (1989); **Trask v. Lockheed Shipbuilding and Construction Company**, 17 BRBS 56 (1985); **Mason v. Bender Welding & Machine Co.**, 16 BRBS 307, 309 (1984). The traditional approach for determining whether an injury is permanent or temporary is to ascertain the date of "maximum medical improvement." The determination of when maximum medical improvement is reached so that claimant's disability may be said to be permanent is primarily a question of fact based on medical evidence. **Lozada v. Director, OWCP**, 903 F.2d 168, 23 BRBS 78 (CRT) (2d Cir. 1990); **Hite v. Dresser Guiberson Pumping**, 22 BRBS 87, 91 (1989); **Care v. Washington Metropolitan Area Transit Authority**, 21 BRBS 248 (1988); **Wayland v. Moore Dry Dock**, 21 BRBS 177 (1988); **Eckley v. Fibrex and Shipping Company**, 21 BRBS 120 (1988); **Williams v. General Dynamics Corp.**, 10 BRBS 915 (1979).

The Benefits Review Board has held that a determination that claimant's disability is temporary or permanent may not be based on a prognosis that claimant's condition may improve and become stationary at some future time. **Meecke v. I.S.O. Personnel Support Department**, 10 BRBS 670 (1979). The Board has also held that a disability need not be "eternal or everlasting" to be permanent and the possibility of a favorable change does not foreclose a finding

of permanent disability. **Exxon Corporation v. White**, 617 F.2d 292 (5th Cir. 1980), **aff'g** 9 BRBS 138 (1978). Such future changes may be considered in a Section 22 modification proceeding when and if they occur. **Fleetwood v. Newport News Shipbuilding and Dry Dock Company**, 16 BRBS 282 (1984), **aff'd**, 776 F.2d 1225, 18 BRBS 12 (CRT) (4th Cir. 1985).

Permanent disability has been found where little hope exists of eventual recovery, **Air America, Inc. v. Director, OWCP**, 597 F.2d 773 (1st Cir. 1979), where claimant has already undergone a large number of treatments over a long period of time, **Meecke v. I.S.O. Personnel Support Department**, 10 BRBS 670 (1979), even though there is the possibility of favorable change from recommended surgery, and where work within claimant's work restrictions is not available, **Bell v. Volpe/Head Construction Co.**, 11 BRBS 377 (1979), and on the basis of claimant's credible complaints of pain alone. **Eller and Co. v. Golden**, 620 F.2d 71 (5th Cir. 1980). Furthermore, there is no requirement in the Act that medical testimony be introduced, **Ballard v. Newport News Shipbuilding & Dry Dock Co.**, 8 BRBS 676 (1978); **Ruiz v. Universal Maritime Service Corp.**, 8 BRBS 451 (1978), or that claimant be bedridden to be totally disabled, **Watson v. Gulf Stevedore Corp.**, 400 F.2d 649 (5th Cir. 1968). Moreover, the burden of proof in a temporary total case is the same as in a permanent total case. **Bell**, **supra**. **See also Walker v. AAF Exchange Service**, 5 BRBS 500 (1977); **Swan v. George Hyman Construction Corp.**, 3 BRBS 490 (1976). There is no requirement that claimant undergo vocational rehabilitation testing prior to a finding of permanent total disability, **Mendez v. Bernuth Marine Shipping, Inc.**, 11 BRBS 21 (1979); **Perry v. Stan Flowers Company**, 8 BRBS 533 (1978), and an award of permanent total disability may be modified based on a change of condition. **Watson v. Gulf Stevedore Corp.**, **supra**.

An employee is considered permanently disabled if he has any residual disability after reaching maximum medical improvement. **Lozada v. General Dynamics Corp.**, 903 F.2d 168, 23 BRBS 78 (CRT) (2d Cir. 1990); **Sinclair v. United Food & Commercial Workers**, 13 BRBS 148 (1989); **Trask v. Lockheed Shipbuilding & Construction Co.**, 17 BRBS 56 (1985). A condition is permanent if claimant is no longer undergoing treatment with a view towards improving his condition, **Leech v. Service Engineering Co.**, 15 BRBS 18 (1982), or if his condition has stabilized. **Lusby v. Washington Metropolitan Area Transit Authority**, 13 BRBS 446 (1981).

A disability is considered permanent as of the date claimant’s condition reaches maximum medical improvement or if the condition has continued for a lengthy period and appears to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. **See Watson v. Gulf Stevedore Corp.**, 400 F.2d 649 (5th Cir. 1968), **cert. denied**. 394 U.S. 976 (1969). If a physician believes that further treatment should be undertaken, then a possibility of improvement exists, and

even if, in retrospect, the treatment was unsuccessful, maximum medical improvement does not occur until the treatment is complete. **Louisiana Ins. Guaranty Assn. v. Abbott,** 40 F.3d 122, 29 BRBS 22(CRT)(5th Cir. 1994); **Leech v. Service Engineering Co.,** 15 BRBS 18 (1982). If surgery is anticipated, maximum medical improvement has not been reached. **Kuhn v. Associated press**, 16 BRBS 46 (1983). If surgery is not anticipated, or if the prognosis after surgery is uncertain, the claimant's condition may be permanent. **Worthington v. Newport News Shipbuilding & Dry Dock Co.**, 18 BRBS 200 (1986); **White v. Exxon Corp.,** 9 BRBS 138 (1978), **aff'd mem**., 617 F.2d 292 (5th Cir. 1982).

On the basis of the totality of the record, I find and conclude that Claimant has been permanently and partially disabled from June 22, 2001, according to the parties' stipulations. (JX 2)

With reference to Claimant's residual work capacity, an employer can establish suitable alternate employment by offering an injured employee a light duty job which is tailored to the employee's physical limitations, so long as the job is necessary and claimant is capable of performing such work. **Walker v. Sun Shipbuilding and Dry Dock Co.**, 19 BRBS 171 (1986); **Darden v. Newport News Shipbuilding and Dry Dock Co.**, 18 BRBS 224 (1986). Claimant must cooperate with the employer's re-employment efforts and if employer establishes the availability of suitable alternate job opportunities, the Administrative Law Judge must consider claimant's willingness to work. **Trans-State Dredging v. Benefits Review Board, U.S. Department of Labor and Tarner**, 731 F.2d 199 (4th Cir. 1984); **Roger's Terminal & Shipping Corp. v. Director, OWCP**, 784 F.2d 687 (5th Cir. 1986). An employee is not entitled to total disability benefits merely because he does not like or desire the alternate job. **Villasenor v. Marine Maintenance Industries, Inc.**, 17 BRBS 99, 102 (1985), **Decision and Order on Reconsideration**, 17 BRBS 160 (1985).

An award for permanent partial disability in a claim not covered by the schedule is based on the difference between claimant's pre-injury average weekly wage and his post-injury wage-earning capacity. 33 U.S.C. §908(c)(21)(h); **Richardson v. General Dynamics Corp.**, 23 BRBS (1990); **Cook v. Seattle Stevedoring Co.**, 21 BRBS 4, 6 (1988). If a claimant cannot return to his usual employment as a result of his injury but secures other employment, the wages which the new job would have paid at the time of claimant's injury are compared to the wages claimant was actually earning pre-injury to determine if claimant has suffered a loss of wage-earning capacity. **Cook**, **supra**. Subsections 8(c)(21) and 8(h) require that wages earned post-injury be adjusted to the wage levels which the job paid at time of injury. **See Walker v. Washington Metropolitan Area Transit Authority**, 793 F.2d 319, 18 BRBS 100 (CRT) (D.C. Cir. 1986); **Bethard v. Sun Shipbuilding & Dry Dock Co.**, 12 BRBS 691, 695 (1980).

It is now well-settled that the proper comparison for determining a loss of wage-earning capacity is between the wages claimant received in his usual employment pre-injury and the wages claimant's post-injury job paid **at the time of his/her injury**. **Richardson**, **supra**; **Cook**, **supra**.

The parties herein now have the benefit of a most significant opinion rendered by the First Circuit Court of Appeals in affirming a matter over which this Administrative Law Judge presided. In **White v. Bath Iron Works Corp.**, 812 F.2d 33 (1st Cir. 1987), Senior Circuit Court Judge Bailey Aldrich framed the issue as follows: "the question is how much claimant should be reimbursed for this loss (of wage-earning capacity), it being common ground that it should be a fixed amount, not to vary from month to month to follow current discrepancies." **White**, **supra**, at 34.

Senior Circuit Judge Aldrich rejected outright the employer's argument that the Administrative Law Judge "must compare an employee's post-injury actual earnings to the average weekly wage of the employee's time of injury" as that thesis is not sanctioned by Section 8(h).

Thus, it is the law in the First Circuit that the post-injury wages must first be adjusted for inflation and then compared to the employee's average weekly wage at the time of his injury. That is exactly what Section 8(h) provides in its literal language.

While there is no obligation on the part of the Employer to rehire Claimant and provide suitable alternate employment, **see**, **e.g.**, **Trans-State Dredging v. Benefits Review Board**, 731 F.2d 199 (4th Cir. 1984), **rev'g and rem. on other grounds Tarner v. Trans-State Dredging**, 13 BRBS 53 (1980), the fact remains that had such work been made available to Claimant years ago, without a salary reduction, perhaps this claim might have been put to rest, especially after the Benefits Review Board has spoken herein and the First Circuit Court of Appeals, in **White**, **supra**.

The law in this area is very clear and if an employee is offered a job at his pre-injury wages as part of his employer's rehabilitation program, this Administrative Law Judge can find that there is no lost wage-earning capacity and that the employee therefore is not disabled. **Swain v. Bath Iron Works Corporation**, 17 BRBS 145, 147 (1985); **Darcell v. FMC Corporation, Marine and Rail Equipment Division**, 14 BRBS 294, 197 (1981). However, I am also cognizant of case law which holds that the employer need not rehire the employee, **New Orleans (Gulfwide) Stevedores, Inc. v. Turner**, 661 F.2d 1031, 1043 (5th Cir. 1981), and that the employer is not required to act as an employment agency. **Royce v. Elrich Construction Co.**, 17 BRBS 157 (1985).

Claimant, in support of his position that he is totally disabled for all types of work, has offered the February 4, 2002

Vocational Rehabilitation Evaluation of Carl Barchi, M.Ed., CDMS, a Vocational Specialist, and Mr. Barchi reports s follows in his evaluation (CX 2):

Claimant: William Talar	Employer: Electric Boat
Town: Oakdale, CT	Referred by: Attorney Nathan Shafner
Current Age: 57	Carrier: Self Insured
Occupation: Sheet Metal Worker	Carrier File: 187688
Diagnoses: Left knee/Back/Hands	Date of Injury: 6-17-98

Background Information

I met with Mr. Talar for about 1 ½ hours on January 30, 2001, and I reviewed his entire file prior to coming to the conclusion at the end of this report.

Mr. Talar, currently 57 years of age, sustained bilateral pleural plaque disease in the course of his 34-year employment at Electric Boat as a sheet metal worker (DOT # 804.281-010). He has not worked in any capacity since 1998, when he was performing shipfitting work for the insured. He has been referred for a vocational assessment to determine current employability.

While Mr. Talar was cooperative and amiable during my meeting with him, I found his vocational presentation skills to be deficient in terms of his interview behavior. He appear quite tense and frustrated. He is totally preoccupied with his many physical issues and symptoms and talks incessantly about them. Other than his work at EB, he has never worked in any other capacity throughout his working live. From a vocational point of view, he is not a good or even viable candidate for competitive job placement.

Personal Information

Mr. Talar is 5'9" tall, weight (is) 215 pounds and is right handed. He has been married to Brenda Talar and they have three children. A daughter, Kris, age 26, lives at home. They live in their own home in Oakdale, CT where Mr. Talar was raised.

Educational and Vocational Information

Mr. Talar earned a high school diploma in 1969 through a home study course. He has no other formal education or vocational training.

His vocational history is uneventful. He was hired by EB as a sheet metal worker in 1962 and has served in that skilled, medium-duty work capacity since that time. He has not held supervisory positions. His highest earnings ever (were) about $40,000/year - at EB, where he indicates he was seldom physically able to perform overtime work due to his physical problems. From 1967 to 1968 and

from 1971 to 1972, he worked for a short time as a truck driver, roofer, and carpenter's helper. Since these latter positions are more than fifteen years ago, they are not considered relevant in terms of any current transferable skills he may have.

Medical/Functional Capacities Information

Daniel Gerardi, MD, re-examined Mr. Talar on behalf of the insured on January 31, 2001. His primary diagnoses were bilateral pleural plaque disease with evidence for calcification and rounded atelectasis, atopic disease and mild airflow obstruction and obstructive sleep apnea. Dr. Gerardi concluded that Mr. Talar was "capable of light work."

Mr. Talar enumerated for me a number of other work and non-work-related medical issues that translate into a number of functional limitations. He has the following additional conditions, all of which are documented in the file:

Shortness of breath (This is related to the above-noted condition.)

Bilateral hearing loss (6%)

Right eye enucleation

Limited neck ROM (10%)

Ulcerative colitis (He needs to use the bathroom 4/5 times per day. Aggravated by normal job stress.)

Bilateral carpal tunnel syndrome (The left is reportedly worse.)

Sleep apnea (He needs to nap 3/5 times per day.)

Transferable Skills Analysis

A TSA was performed, using Mr. Talar's vocational history and the restrictions imposed by Dr. Gerardi. Using a DOT-based, TSA software program, I found no suitable, alternative (transferable) jobs for Mr. Green to consider.

To suggest - as a Labor Market Survey in the file suggests - that Mr. Talar has transferable skills that enable him to function as a security guard, dispatcher, customer service representative or cashier is inaccurate at best. In fact he has no proven skills in any of these occupations because he has never worked in any of them. His sheet metal skills are not directly transferable to security and/or customer service-type jobs. He has a list of jobs he applied for during January, 2001 but to date has been unsuccessful even in procuring an initial interview.

Conclusion

Mr. Talar, age 57, has performed only strenuous, medium-duty sheet metal work throughout his occupational life. He has been limited to lifting no more than 20 pounds (light duty), and he cannot be exposed to any unclean or otherwise unhealthy atmospheric conditions. As such, he cannot perform his previous medium work, and a TSA analysis was unable to generate feasible, alternative occupations - given the severe physical restrictions imposed as per file documentation. Mr. Talar has not had any vocational rehabilitation services from the OWCP Program in Boston. His interpersonal presentation style is seriously compromised by his preoccupation with his numerous medical conditions, by his observed nervousness and by being overly talkative. A Labor Market Survey in the file opines he can perform security guard, dispatcher, customer service and cashier work; however, he has not been able to secure any of the jobs listed on the LMS. His lack of success in job placement should not seem surprising since he has no marketable, transferable skills - given his very limited job history and his exceptional number of vocationally-limiting physical problems.

Finally, I propose that Mr. Talar is neither marketable nor "placeable" in the competitive labor market. Vocationally, I think his chances for rehabilitation (are) currently poor to nil and will remain so into the foreseeable future.

On the other hand, the Employer relies on the March 16, 2001 and April 15, 2002 Labor Market Survey of Jennifer Vanderleeden in an attempt to show that Claimant is not totally disabled, notwithstanding his multiple problems, ironically, provide the basis for the Section 8(f) application.

Ms. Vanderleeden, in her first report (RX 6), opines that Claimant has the residual work capacity and transferable skills to perform light duty and sedentary work as a security guard, dispatcher, customer service representative, cashier, assembler and front desk clerk and she concluded as follows at page 7 of her report:

SUMMARY:

Jobs	Current Rates	Rates as of 1998	Number of Openings
Security Guards	$6.50 per hour to $15.00 per hour	Minimum wage	7
Dispatcher	$10.00 per hour to $12.00 per hour	$10.00 per hour	2
Customer Service Rep.	$8.00 per hour	N/A	2
Cashier	$8.00 per hour	N/A	2
Assembler	$8.00 per hour to $9.00 per hour	$7.00 per hour	4
Inspector	$10.00 per hour	$8.00 per hour	1
Front Desk Clerk	$8.00 per hour to $9.00 per hour	$6 to $7.00 per hour	2

CONCLUSIONS:

There were 20 openings found in the occupations categories provided above that are appropriate for Mr. Talar based upon his

transferable skills and all of the physical restrictions provided by the medical reports provided. Hourly rates were found to be between $8.00 per hour to $15.00 per hour. Wages reported by the respondent employers from 1998 were found to be between $5.15 per hour to $8.00 per hour. With the above listed openings, an earning capacity is established for Mr. Talar.

In her updated survey (RX 10), Ms. Vanderleeden reiterated her opinions that Claimant could perform alternate work as a security guard, dispatcher, front desk clerk, receptionist and host and she concluded as follows on page 10:

CONCLUSION:

There were 17 openings found in the occupations categories that appear to be appropriate for Mr. Talar based upon his transferable skills and all of the physical capabilities provided by the medical reports in the file. Hourly rates were found to be between $8.00 per hour and $10.00 per hour. Wages reported by the respondent employers from 1998 were found to be between $5.15 per hour and $8.00 per hour. With the above listed openings, an earning capacity is established for Mr. Talar.

As indicated above, the Employer has offered Labor Market Surveys (RX 6 and RX 10) in an attempt to show the availability of work for Claimant at various jobs. I do accept the results of that thorough survey which consisted of the counselor making a number of telephone calls to prospective employers.

It is well-settled that this Employer must show the availability of actual, not theoretical, employment opportunities by identifying specific jobs available for Claimant in close proximity to the place of injury. **Royce v. Erich Construction Co.**, 17 BRBS 157 (1985). For the job opportunities to be realistic, the Employer must establish their precise nature and terms, **Reich v. Tracor Marine, Inc.**, 16 BRBS 272 (1984), and the pay scales for the alternate jobs. **Moore v. Newport News Shipbuilding & Dry Dock Co.**, 7 BRBS 1024 (1978). While this Administrative Law Judge may rely on the testimony of a vocational counselor that specific job openings exist to establish the existence of suitable jobs, **Southern v. Farmers Export Co.**, 17 BRBS 64 (1985), employer's counsel must identify specific available jobs; generalized labor market surveys are not enough. **Kimmel v. Sun Shipbuilding & Dry Dock Co.**, 14 BRBS 412 (1981).

The Labor Market Survey and the addendum (RX 6 and RX 10) can be relied upon by this Administrative Law Judge because there is complete information about the specific nature of the duties of the jobs that Ms. Vanderleeden identifies, which jobs are within the doctor's physical restrictions.

In view of the foregoing, I accept and credit the results of the Labor Market Surveys because I conclude that those jobs constitute, as a matter of fact or law, **suitable** alternative employment or **realistic** job opportunities. In this regard, **see Armand v. American Marine Corporation**, 21 BRBS 305, 311, 312 (1988); **Horton v. General Dynamics Corp.**, 20 BRBS 99 (1987). **Armand** and **Horton** are significant pronouncements by the Board on this important issue.

The parties have now stipulated, and the Labor Market Surveys, that Claimant is partially disabled and that, on and after June 23, 2001, he is entitled to weekly permanent partial disability benefits at the rate of $325.00, pursuant to Section 8(c)(21) of the Act.

Medical Expenses

An Employer found liable for the payment of compensation is, pursuant to Section 7(a) of the Act, responsible for those medical expenses reasonably and necessarily incurred as a result of a work-related injury. **Perez v. Sea-Land Services, Inc.**, 8 BRBS 130 (1978). The test is whether or not the treatment is recognized as appropriate by the medical profession for the care and treatment of the injury. **Colburn v. General Dynamics Corp.**, 21 BRBS 219, 22 (1988); **Barbour v. Woodward & Lothrop, Inc.**, 16 BRBS 300 (1984). Entitlement to medical services is never time-barred where a disability is related to a compensable injury. **Addison v. Ryan-Walsh Stevedoring Company**, 22 BRBS 32, 36 (1989); **Mayfield v. Atlantic & Gulf Stevedores**, 16 BRBS 228 (1984); **Dean v. Marine Terminals Corp.**, 7 BRBS 234 (1977). Furthermore, an employee's right to select his own physician, pursuant to Section 7(b), is well settled. **Bulone v. Universal Terminal and Stevedore Corp.**, 8 BRBS 515 (1978). Claimant is also entitled to reimbursement for reasonable travel expenses in seeking medical care and treatment for his work-related injury. **Tough v. General Dynamics Corporation**, 22 BRBS 356 (1989); **Gilliam v. The Western Union Telegraph Co.**, 8 BRBS 278 (1978).

In **Shahady v. Atlas Tile & Marble**, 13 BRBS 1007 (1981), **rev'd on other grounds**, 682 F.2d 968 (D.C. Cir. 1982), **cert. denied**, 459 U.S. 1146, 103 S.Ct. 786 (1983), the Benefits Review Board held that a claimant's entitlement to an initial free choice of a physician under Section 7(b) does not negate the requirement under Section 7(d) that claimant obtain employer's authorization prior to obtaining medical services. **Banks v. Bath Iron Works Corp.**, 22 BRBS 301, 307, 308 (1989); **Jackson v. Ingalls Shipbuilding Division, Litton Systems, Inc.**, 15 BRBS 299 (1983); **Beynum v. Washington Metropolitan Area Transit Authority**, 14 BRBS 956 (1982). However, where a claimant has been refused treatment by the employer, he need only establish that the treatment he subsequently procures on his own initiative was necessary in order to be

entitled to such treatment at the employer's expense. **Atlantic & Gulf Stevedores, Inc. v. Neuman**, 440 F.2d 908 (5th Cir. 1971); **Matthews v. Jeffboat, Inc.**, 18 BRBS at 189 (1986).

An employer's physician's determination that Claimant is fully recovered is tantamount to a refusal to provide treatment. **Slattery Associates, Inc. v. Lloyd**, 725 F.2d 780 (D.C. Cir. 1984); **Walker v. AAF Exchange Service**, 5 BRBS 500 (1977). All necessary medical expenses subsequent to employer's refusal to authorize needed care, including surgical costs and the physician's fee, are recoverable. **Roger's Terminal and Shipping Corporation v. Director, OWCP**, 784 F.2d 687 (5th Cir. 1986); **Anderson v. Todd Shipyards Corp.**, 22 BRBS 20 (1989); **Ballesteros v. Willamette Western Corp.**, 20 BRBS 184 (1988).

Section 7(d) requires that an attending physician file the appropriate report within ten days of the examination. Unless such failure is excused by the fact-finder for good cause shown in accordance with Section 7(d), claimant may not recover medical costs incurred. **Betz v. Arthur Snowden Company**, 14 BRBS 805 (1981). **See also** 20 C.F.R. §702.422. However, the employer must demonstrate actual prejudice by late delivery of the physician's report. **Roger's Terminal**, **supra**.

It is well-settled that the Act does not require that an injury be disabling for a claimant to be entitled to medical expenses; it only requires that the injury be work related. **Romeike v. Kaiser Shipyards**, 22 BRBS 57 (1989); **Winston v. Ingalls Shipbuilding**, 16 BRBS 168 (1984); **Jackson v. Ingalls Shipbuilding**, 15 BRBS 299 (1983).

On the basis of the totality of the record, I find and conclude that Claimant has shown good cause, pursuant to Section 7(d). Claimant advised the Employer of his work-related injury in a timely manner and requested appropriate medical care and treatment. However, the Employer did not accept the claim and did not authorize such medical care. Thus, any failure by Claimant to file timely the physician's report is excused for good cause as a futile act and in the interests of justice as the Employer refused to accept the claim. Accordingly, the Employer shall pay for, and authorize, reasonable and necessary medical care and treatment relating to his lung condition, commencing on November 27, 1998.

Section 14(e)

Claimant is not entitled to an award of additional compensation, pursuant to the provisions of Section 14(e), as the Employer has accepted the claim, provided the necessary medical care and treatment and voluntarily paid compensation benefits to Claimant for certain periods of time and timely controverted his entitlement to further benefits. **Ramos v. Universal Dredging**

Corporation, 15 BRBS 140, 145 (1982); **Garner v. Olin Corp.**, 11 BRBS 502, 506 (1979).

Section 8(f) of the Act

Regarding the Section 8(f) issue, the essential elements of that provision are met, and employer's liability is limited to one hundred and four (104) weeks, if the record establishes that (1) the employee had a pre-existing permanent partial disability, (2) which was manifest to the employer prior to the subsequent compensable injury and (3) which combined with the subsequent injury to produce or increase the employee's permanent total or partial disability, a disability greater than that resulting from the first injury alone. **Lawson v. Suwanee Fruit and Steamship Co.**, 336 U.S. 198 (1949); **Director, OWCP v. Luccitelli**, 964 F.2d 1303, 26 BRBS 1 (CRT) (2d Cir. 1992), **rev'g Luccitelli v. General Dynamics Corp.**, 25 BRBS 30 (1991); **Director, OWCP v. General Dynamics Corp.,** 982 F.2d 790 (2d Cir. 1992); **FMC Corporation v. Director, OWCP**, 886 F.2d 1185, 23 BRBS 1 (CRT) (9th Cir. 1989); **Director, OWCP v. Cargill, Inc.**, 709 F.2d 616 (9th Cir. 1983); **Director, OWCP v. Newport News & Shipbuilding & Dry Dock Co.**, 676 F.2d 110 (4th Cir. 1982); **Director, OWCP v. Sun Shipbuilding & Dry Dock Co.**, 600 F.2d 440 (3rd Cir. 1979); **C & P Telephone v. Director, OWCP**, 564 F.2d 503 (D.C. Cir. 1977); **Equitable Equipment Co. v. Hardy**, 558 F.2d 1192 (5th Cir. 1977); **Shaw v. Todd Pacific Shipyards**, 23 BRBS 96 (1989); **Dugan v. Todd Shipyards**, 22 BRBS 42 (1989); **McDuffie v. Eller and Co.**, 10 BRBS 685 (1979); **Reed v. Lockheed Shipbuilding & Construction Co.**, 8 BRBS 399 (1978); **Nobles v. Children's Hospital**, 8 BRBS 13 (1978). The provisions of Section 8(f) are to be liberally construed. **See Director v. Todd Shipyard Corporation**, 625 F.2d 317 (9th Cir. 1980). The benefit of Section 8(f) is not denied an employer simply because the new injury merely aggravates an existing disability rather than creating a separate disability unrelated to the existing disability. **Director, OWCP v. General Dynamics Corp.**, 705 F.2d 562, 15 BRBS 30 (CRT) (1st Cir. 1983); **Kooley v. Marine Industries Northwest**, 22 BRBS 142, 147 (1989); **Benoit v. General Dynamics Corp.**, 6 BRBS 762 (1977).

The employer need not have actual knowledge of the pre-existing condition. Instead, "the key to the issue is the availability to the employer of knowledge of the pre-existing condition, not necessarily the employer's actual knowledge of it." **Dillingham Corp. v. Massey**, 505 F.2d 1126, 1228 (9th Cir. 1974). Evidence of access to or the existence of medical records suffices to establish the employer was aware of the pre-existing condition. **Director v. Universal Terminal & Stevedoring Corp.**, 575 F.2d 452 (3d Cir. 1978); **Berkstresser v. Washington Metropolitan Area Transit Authority**, 22 BRBS 280 (1989), **rev'd and remanded on other grounds sub nom. Director v. Berstresser, 921 F.2d 306 (D.C. Cir. 1990)**; **Reiche v. Tracor Marine, Inc.**, 16 BRBS 272, 276 (1984);

Harris v. Lambert's Point Docks, Inc., 15 BRBS 33 (1982), **aff'd**, 718 F.2d 644 (4th Cir. 1983). **Delinski v. Brandt Airflex Corp.**, 9 BRBS 206 (1978). Moreover, there must be information available which alerts the employer to the existence of a medical condition. **Eymard & Sons Shipyard v. Smith**, 862 F.2d 1220, 22 BRBS 11 (CRT) (5th Cir. 1989); **Armstrong v. General Dynamics Corp.**, 22 BRBS 276 (1989); **Berkstresser**, **supra**, at 283; **Villasenor v. Marine Maintenance Industries**, 17 BRBS 99, 103 (1985); **Hitt v. Newport News Shipbuilding and Dry Dock Co.**, 16 BRBS 353 (1984); **Musgrove v. William E. Campbell Company**, 14 BRBS 762 (1982). A disability will be found to be manifest if it is "objectively determinable" from medical records kept by a hospital or treating physician. **Falcone v. General Dynamics Corp.**, 16 BRBS 202, 203 (1984). Prior to the compensable second injury, there must be a medically cognizable physical ailment. **Dugan v. Todd Shipyards**, 22 BRBS 42 (1989); **Brogden v. Newport News Shipbuilding and Dry Dock Company**, 16 BRBS 259 (1984); **Falcone**, **supra**.

The pre-existing permanent partial disability need not be economically disabling. **Director, OWCP v. Campbell Industries**, 678 F.2d 836, 14 BRBS 974 (9th Cir. 1982), **cert. denied**, 459 U.S. 1104 (1983); **Equitable Equipment Company v. Hardy**, 558 F.2d 1192, 6 BRBS 666 (5th Cir. 1977); **Atlantic & Gulf Stevedores v. Director, OWCP**, 542 F.2D 602 (3d Cir. 1976).

An x-ray showing pleural thickening, followed by continued exposure to the injurious stimuli, establishes a pre-existing permanent partial disability. **Topping v. Newport News Shipbuilding**, 16 BRBS 40 (1983); **Musgrove v. William E. Campbell Co.**, 14 BRBS 762 (1982).

Section 8(f) relief is not applicable where the permanent total disability is due solely to the second injury. In this regard, **see Director, OWCP (Bergeron) v. General Dynamics Corp.**, 982 F.2d 790, 26 BRBS 139 (CRT)(2d Cir. 1992); **Luccitelli v. General Dynamics Corp.**, 964 F.2d 1303, 26 BRBS 1 (CRT)(2d Cir. 1992); **CNA Insurance Company v. Legrow**, 935 F.2d 430, 24 BRBS 202 (CRT)(1st Cir. 1991) In addressing the contribution element of Section 8(f), the United States Court of Appeals for the Second Circuit, in whose jurisdiction the instant case arises, has specifically stated that the employer's burden of establishing that a claimant's subsequent injury alone would not have cause claimant's permanent total disability is not satisfied merely by showing that the pre-existing condition made the disability worse than it would have been with only the subsequent injury. **See Director, OWCP v. General Dynamics Corp. (Bergeron), supra.**

Section 8(f) relief has now been withdrawn as an issue herein. (JX 2)

Attorney's Fee

Claimant's attorney, having successfully prosecuted this matter, is entitled to a fee assessed against the Employer as a self-insurer. Claimant's prior attorney filed a fee application on September 6, 2002 (CX 31), concerning services rendered and costs incurred in representing Claimant between January 3, 2002 and June 30, 2002. Attorney Carolyn P. Kelly seeks a fee of $9,038.64 (including expenses) based on 39.50 hours of attorney time at $200.00 per hour and 6.50 hours of paralegal time at $55.00 per hour.

The Employer has also agreed to pay to the law firm of Embry and Neusner an attorney's fee of $2,000.00 representing ten (10) hours of legal services at $200.00 per hour. (JX 2)

In accordance with established practice, I will consider only those services rendered and costs incurred after July 25, 2001, the date of the informal conference. Services rendered prior to this date should be submitted to the District Director for her consideration.

In light of the nature and extent of the excellent legal services rendered to Claimant by his attorneys, the amount of compensation obtained for Claimant and the Employer's comments on the requested fee, I find a legal fee of $9,396.14 (including expenses of $1,138.64) is reasonable and in accordance with the criteria provided in the Act and regulations, 20 C.F.R. §702.132, and is hereby approved. The expenses are approved as reasonable and necessary litigation expenses. My approval of the hourly rates is limited to the factual situation herein.

ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I issue the following compensation order. The specific dollar computations of the compensation award shall be administratively performed by the District Director.

It is therefore **ORDERED** that:

1. The Employer as a self-insurer shall pay to the Claimant compensation for his temporary total disability from November 27, 1998 through June 22, 2001, based upon an average weekly wage of $676.33, such compensation to be computed in accordance with Section 8(b) of the Act.

2. Commencing on January 31, 2001, the Employer shall pay to the Claimant compensation benefits for his permanent partial disability, plus the applicable annual adjustments provided in Section 10 of the Act, as the weekly rate of $325.00, such

compensation to be computed in accordance with Section 8(c)(21) of the Act, and such benefits shall continue until further **ORDER** of this Court.

3. The Employer shall receive credit for all amounts of compensation previously paid to the Claimant as a result of his November 25, 1998 injury.

4. The Employer shall furnish such reasonable, appropriate and necessary medical care and treatment as the Claimant's work-related lung condition referenced herein may require, commencing on November 27, 1998, subject to the provisions of Section 7 of the Act.

5. The Employer shall pay to Claimant's attorney, the law firm of Embry and Neusner, the sum of $2,000.00 as a reasonable fee for representing Claimant herein before the Office of Administrative Law Judges.

6. The Employer shall also pay to Attorney Carolyn P. Kelly a reasonable legal fee of $9,396.14, including expenses, for representing Claimant between January 3, 2002 and June 20, 2002.

7. By agreement of the parties, if Claimant develops lung cancer in the future, it will be considered a new injury and Electric Boat Corporation retains the right to challenge liability and causation of Claimant’s lung cancer to his maritime employment at the Employer’s shipyard.

A

DAVID W. DI NARDI
District Chief Judge

Boston, Massachusetts
DWD:jl